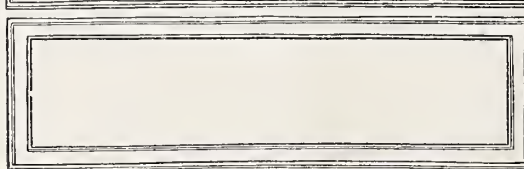
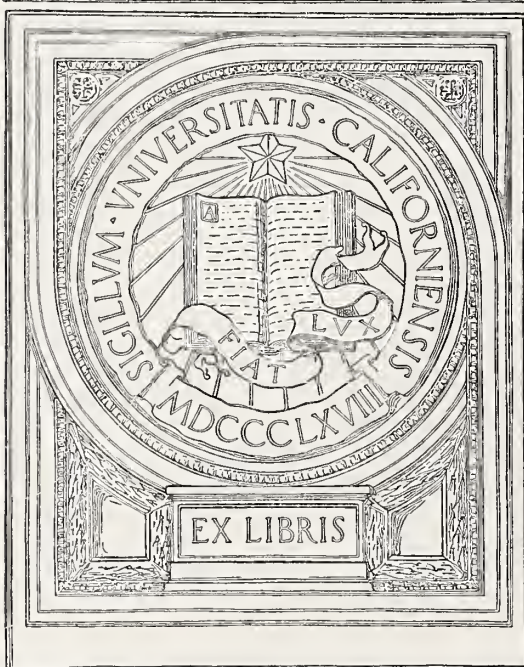




UNIVERSITY OF CALIFORNIA  
MEDICAL CENTER LIBRARY  
SAN FRANCISCO













Digitized by the Internet Archive  
in 2016

<https://archive.org/details/journalofmedical54medi>





**JOURNAL**  
OF THE MEDICAL  
ASSOCIATION

JANUARY / 1965  
*Georgia*

U.C. MEDICAL CENTER LIBRARY

FEB 4 1965

San Francisco 22

# DOCTOR: WE URGENTLY NEED YOUR OPINION

FILL OUT YELLOW FORM INSIDE

## DOCTOR: WE URGENTLY NEED YOUR OPINION!

It is of considerable importance to the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA that the following questionnaire be completed, removed from your journal and mailed to the Medical Association of Georgia as shown below. We urge you to take just a moment for this task, with the assurance that your effort will help us produce a better journal for you.

1. My chief professional interest is general practice ☐ or specialty ☐
2. I rate the scientific papers in the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA as:  
☐ Excellent ☐ Fair ☐ Poor
3. I read the pharmaceutical advertising in the journal:  
☐ Regularly ☐ Sometimes ☐ Rarely
4. I have referred to the local advertising in the journal:  
☐ Often ☐ Sometimes ☐ Never
5. Please give the name of one local service, firm, or institution (professional or nonmedical) which you have referred to, or purchased from, as a result of seeing its advertising in your journal.
6. Please list the professional journals you read in order of preference. (You may show your opinion of your own medical journal by its position on this list.)  
1. \_\_\_\_\_ 4. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_
7. When examining your journal do you more often read papers by authors or from hospitals with which you are personally familiar than articles from other sources? ☐ Yes ☐ No
8. What feature do you like best in your journal?
9. What do you like least?
10. What suggestions would you like to make for improvement of this Journal? (Use back of sheet for your suggestions.)

PLEASE TEAR OUT AND RETURN TO: The Medical Association of Georgia  
926 Peachtree Street, N.E.  
Atlanta, Georgia 30309

192746



epilepsy may limit  
opportunity...

## Dilantin® (diphenylhydantoin)

PARKE-DAVIS

### extends horizons

This agent "...has brought new hope to an entire generation of seizure patients...With judicious use, it may be said that it alone is responsible for the prevention of more seizures than any other drug."\*

DILANTIN (diphenylhydantoin) can help your epileptic patient to earn a livelihood...to prove his worth...and to share in the daily give-and-take as a full-fledged member of the workaday world.

*Indications:* Grand mal epilepsy and certain other convulsive states.

*Precautions:* Toxic effects are infrequent: allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Eruptions then usually subside. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia, aplastic anemia, leukopenia, granulocytopenia and pancytopenia have been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.

DILANTIN (diphenylhydantoin sodium) is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm.

\*Roseman, E.: *Neurology* 11:912, 1961.

33664

**PARKE-DAVIS**

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232



JOURNAL  
OF THE MEDICAL  
ASSOCIATION

Georgia

Contents

EDITOR  
Edgar Woody, Jr., M.D.

MANAGING EDITOR  
Merrillie M. Davis

STAFF  
Thelma V. Franklin, Business

CONTRIBUTING EDITORS  
Herbert S. Alden, M.D.; Preston D. Ellington, M.D.; Thomas Findley, M.D.; J. Willis Hurst, M.D.; Charles S. Jones, M.D.; Arthur M. Knight, Jr., M.D.; Arthur J. Merrill, M.D.; Lester Rumble, Jr., M.D.; Peter L. Scardino, M.D.; Patrick C. Shea, Jr., M.D.; Robert H. Vaughan, M.D.

PUBLICATIONS COMMITTEE  
J. G. McDaniel, M.D.; George H. Alexander, M.D.; George R. Dillinger, M.D.; John Kirk Train, M.D.; A. W. Simpson, M.D.; John T. Mauldin, M.D.; John S. Atwater, M.D.; C. R. Andrews, M.D.

THE ASSOCIATION  
J. G. McDaniel, M.D., Pres.; George H. Alexander, M.D., Pres-Elect; George R. Dillinger, M.D., Past Pres.; A. W. Simpson, M.D., Chm. of Council; John T. Mauldin, M.D., Sec.; John S. Atwater, M.D., Treas.; J. Frank Walker, M.D., Speaker; Mr. Milton D. Krueger, Exec. Sec.; Mr. James M. Moffett, Asst. Exec. Sec.; Mrs. Catherine Wooten, Asst. Exec. Sec.

THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and copyrighted, 1965, by the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309. Published monthly under the direction of the Council of the Association. Subscription rate: \$7 per year; \$1 per single copy. Second-class postage paid at Atlanta, Georgia.

Scientific Articles

THE FETAL HEART RATE E. J. Quilligan, M.D.	3
NEWER USES OF OLD DRUGS IN THE TREATMENT OF URINARY TRACT INFECTIONS James O. Morse, M.D.	8
IRON LOADING ANEMIA H. Chan White, Jr., M.D.	12
WHEN DOES PREGNANCY TEST BECOME NEGATIVE AFTER NORMAL DELIVERY, INCOMPLETE ABORTION AND MISSED ABORTION? D. Frank Mullins, Jr., M.D.; Lewis R. Collins, M.D., and John R. Clark, M.D.	16

Editorials

AN URGENT REQUEST	18
ORTHOSTATIC HYPOTENSION	18
AMA CLINICAL CONVENTION HIGHLIGHTS	19

Features

President's Letter	21
Cancer Page	22
Heart Page	24
Legal Page	25
Mental Health Page	27

The Association

Deaths	27
Societies	28
Personals	28
Advertising Index	40A
Calendar	7

Cover

Design by John Stuart McKenzie, Atlanta



How can just 1 calorie  
taste so good?

An elegant evening . . . candlelight, crystal,  
dinner for two. And the elegant complement  
...new one-calorie drink. The difference in Tab  
is flavor. You see, anyone can take the calories  
out of a soft drink. But it took The Coca-Cola  
Company to keep the flavor in. Tab...only one  
calorie in every six ounces. Keep tab with Tab.

NEW!

The Coca-Cola Company  
kept the flavor in

**TaB**  
THE COCA-COLA COMPANY





## THE FETAL HEART RATE

E. J. Quilligan, M.D., *Cleveland, Ohio*

■ ***Fetal bradycardia in the absence of uterine contractions  
is thought to indicate lowered fetal oxygenation.***

ONE HUNDRED and forty-six years ago Mayor of Geneva<sup>1</sup> first heard the fetal heart beat. About four years later de Kegaradec<sup>2</sup> in an extensive monograph described changes in the heart rate associated with uterine contractions and found a higher incidence of depressed infants associated with a heart rate less than 100 beats per minute during labor. Since that date numerous papers have been written confirming the increased fetal mortality associated with fetal bradycardia and/or meconium staining of the amniotic fluid. Thus the fetal heart rate has a long history as a prognosticator of fetal well-being.

### Monitoring Difficulties

The difficulties of monitoring the fetal heart rate throughout labor with a stethoscope are twofold. First, there aren't enough doctors and/or nurses to stay with the patient continuously assuming one could keep a stethoscope in place for several hours. Second, the errors associated with counting can be multiple and of considerable magnitude. This has recently been most vividly demonstrated by Hon.<sup>3</sup> Utilizing both electronic and stethoscope counting he showed that there could be a discrepancy of greater than 20 beats per minute in counting.

These difficulties have led to a search for electronic methods of counting and recording the fetal heart rate. The initial step was taken by Cremer.<sup>4</sup> In 1903, while doing an electrocardiogram on a pregnant mother, he noted small breaks in the base line occurring with a regular rhythm and with a frequency much faster than the maternal heart rate. He felt this was the fetal electrocardiogram. There were those colleagues who felt that this was artifact, but he was subsequently proven correct.

The ensuing 50 years have involved fundamentally electronic methodology. Two primary approaches have been taken, continuous electrocardiography and continuous phonocardiography, with conversion of both to rate.

### Phonocardiography

Phonocardiography involves, in essence, substituting a very sensitive microphone for the stethoscope. The phonocardiogram can be very effective in the non-laboring quiet patient and some very excellent studies have recently been performed by Hellman<sup>5</sup> and associates using a phonocardiographic technique. In the patient in labor, the phonocardiogram has been in general less satisfactory due to the fact that the microphone picks up all the extraneous noises frequently found in the labor room.

### Electrocardiography

Electrocardiographic recording has gone through several modifications in recent years. The advent of high gain low noise amplifiers has enabled investigators to record the fetal EKG from the maternal anterior abdominal wall with a greater than 80 per cent success rate during the last six weeks of pregnancy. The principal difficulty with abdominal recording has been the occurrence of both the maternal and fetal EKG on the same trace as is illustrated in Figure 1. This implies that determination of rate must be on a manual basis. The aim of several electronic engineers has been to obliterate the maternal signal from the tracing in order that the fetal signal also may be fed directly into a heart rate meter for instantaneous on-line determination of the fetal heart rate. Hon<sup>6</sup> has attempted this obliteration by two techniques, blanking and cancelling. Blanking takes cognizance of the fact that the maternal signal is usually twice the size of the fetal signal and designing suitable electronic circuitry to obliterate this large maternal signal. The can-

*From the Department of Obstetrics and Gynecology, Metropolitan General Hospital, and Western Reserve University.*

*Supported by U. S. Public Health Grant No. GM 06866-04.*

*Presented at the 110th Annual Session of the Medical Association of Georgia, May 4, 1964, Macon, Georgia.*

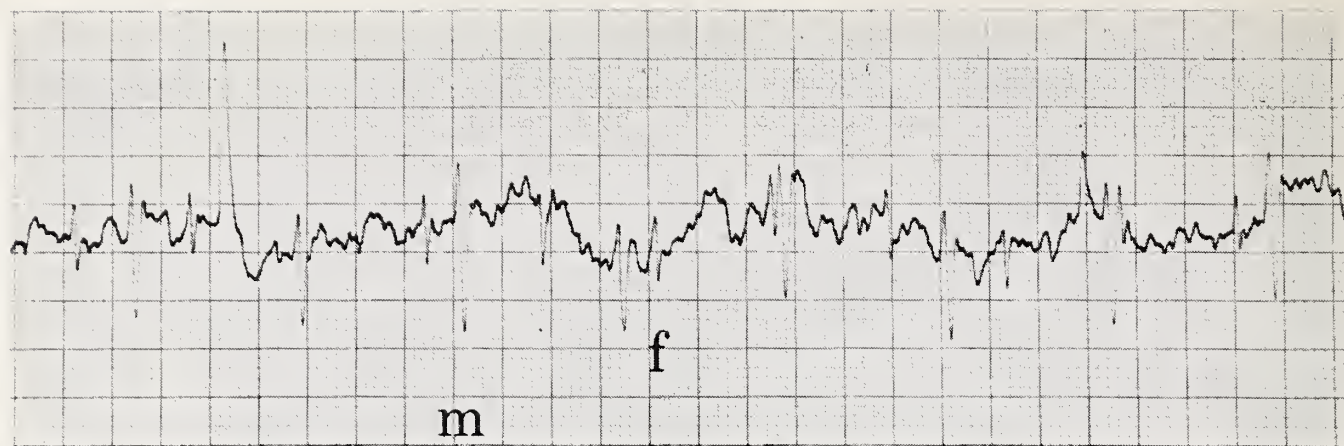


FIGURE 1

Simultaneous Maternal and Fetal EKG Recorded From Anterior Abdominal Wall Electrodes

M=Typical Maternal Complex

F=Typical Fetal Complex

celling technique involves obtaining a pure maternal signal from some part of the body other than the abdomen. This pure maternal signal is subtracted from the maternal and fetal signal leaving only the fetal signal remaining. Neither of these techniques is perfected as yet but do offer possibilities.

### Maternal Complexes

The above difficulties could be resolved if one could obtain a fetal signal unadulterated by maternal complexes (see Figure 2). Hon,<sup>7</sup> Hunter,<sup>8</sup> and Calderyo-Barcia<sup>9</sup> have all done this by placing an electrode directly on the fetus. Hon and Hunter utilizing electrodes that attach to the fetal scalp which are inserted when the cervix is two cm dilated and the membranes ruptured. This limits their usefulness to labor. Calderyo-Barcia, on the other hand, inserts a thin wire electrode transabdominally into the fetal buttock and thus can record with the membranes intact.

With the advances in instrumentation have come some advances in interpretation. The question must be asked and has been asked "What do the changes in rate signify?" either to the obstetrician, or more importantly, to the fetus. Several heart rate patterns have been observed by Hon, Calderyo-Barcia, and ourselves. The first pattern might be called fetal eucardia, a rate at  $140 \pm 20$  beats per minute which remains relatively stable throughout labor. The second pattern is fetal tachycardia or a rate

above 160 beats per minute. The third is fetal bradycardia (rate less than 100 beats per minute) which occurs only during uterine contractions (see Figure 3). The fourth type is a fetal bradycardia occurring either late in uterine contractions and/or when the uterus is not contracting (see Figure 4). These patterns were initially described by Hon.<sup>10</sup>

Fetal eucardia is felt in general to reflect a normal intrauterine fetal homeostasis. There are, however, instances in which it is quite conceivable that the fetus may have a chronic oxygen deficit and still have a normal heart rate. For example, studies have shown the oxygen tension in the fetus to be decreased in pre-eclampsia, diabetes and placental insufficiency, yet most of these infants have a normal heart rate.

Tachycardia, if adult standards are applied, should indicate mild hypoxia. In the past it has been generally felt that fetal reactions were quite different from the adult, bradycardia being the primary manifestation of lowered fetal oxygen. Fairly recent animal evidence indicates that this is incorrect. Reynolds and Paul<sup>11</sup> found that giving the maternal sheep ten per cent oxygen to breathe would cause fetal tachycardia about 20 per cent of the time and only when seven per cent oxygen was inhaled by the mother would fetal bradycardia always insue. We have also shown that fetuses with a mean heart rate above 160 beats per minute are more acidotic than the normal (see Table I).

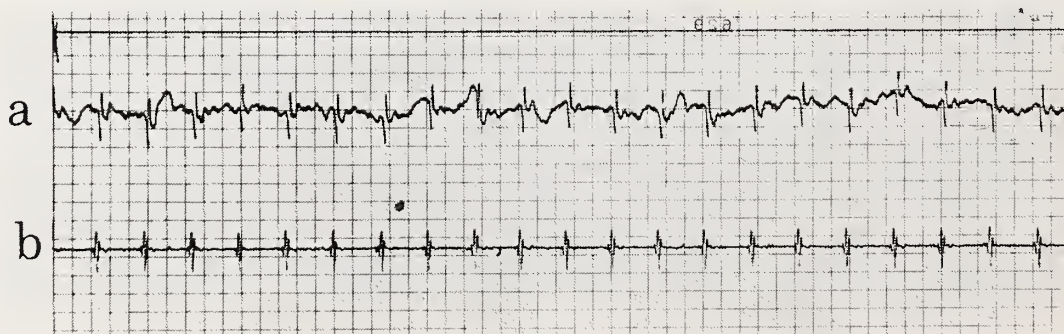


FIGURE 2

Pure Fetal Complexes Recorded with Scalp Electrode

A=Raw Fetal Complex

B=Filtered Fetal Complex



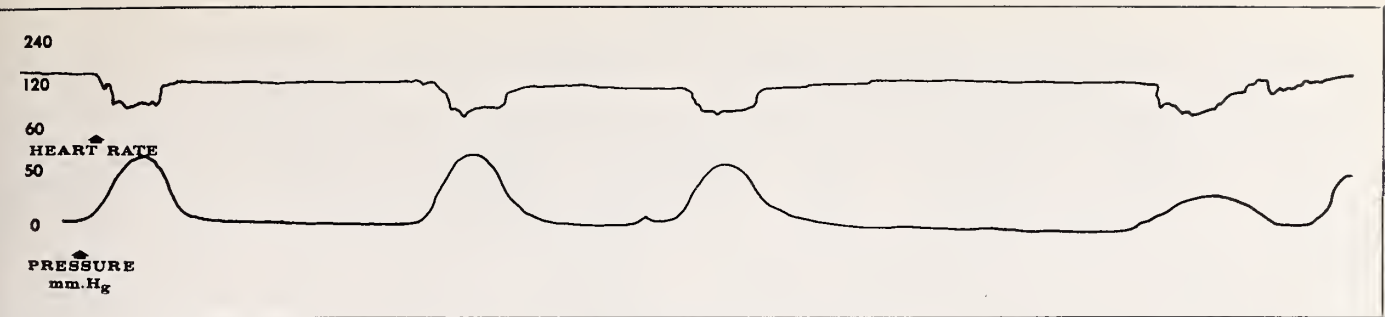


FIGURE 3

Fetal Bradycardia Occurring with Uterine Contractions. Note the onset of bradycardia early in contraction cycle and re-  
turn of heart rate to normal levels by the end of contractions.

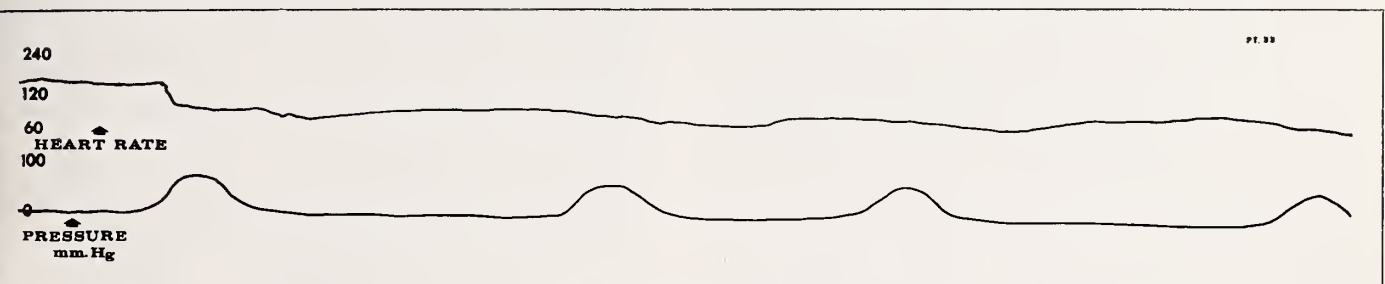


FIGURE 4

Bradycardia Lasting Throughout Several Contractions. This bradycardia was associated with maternal hypotension fol-  
lowing conduction anesthesia.

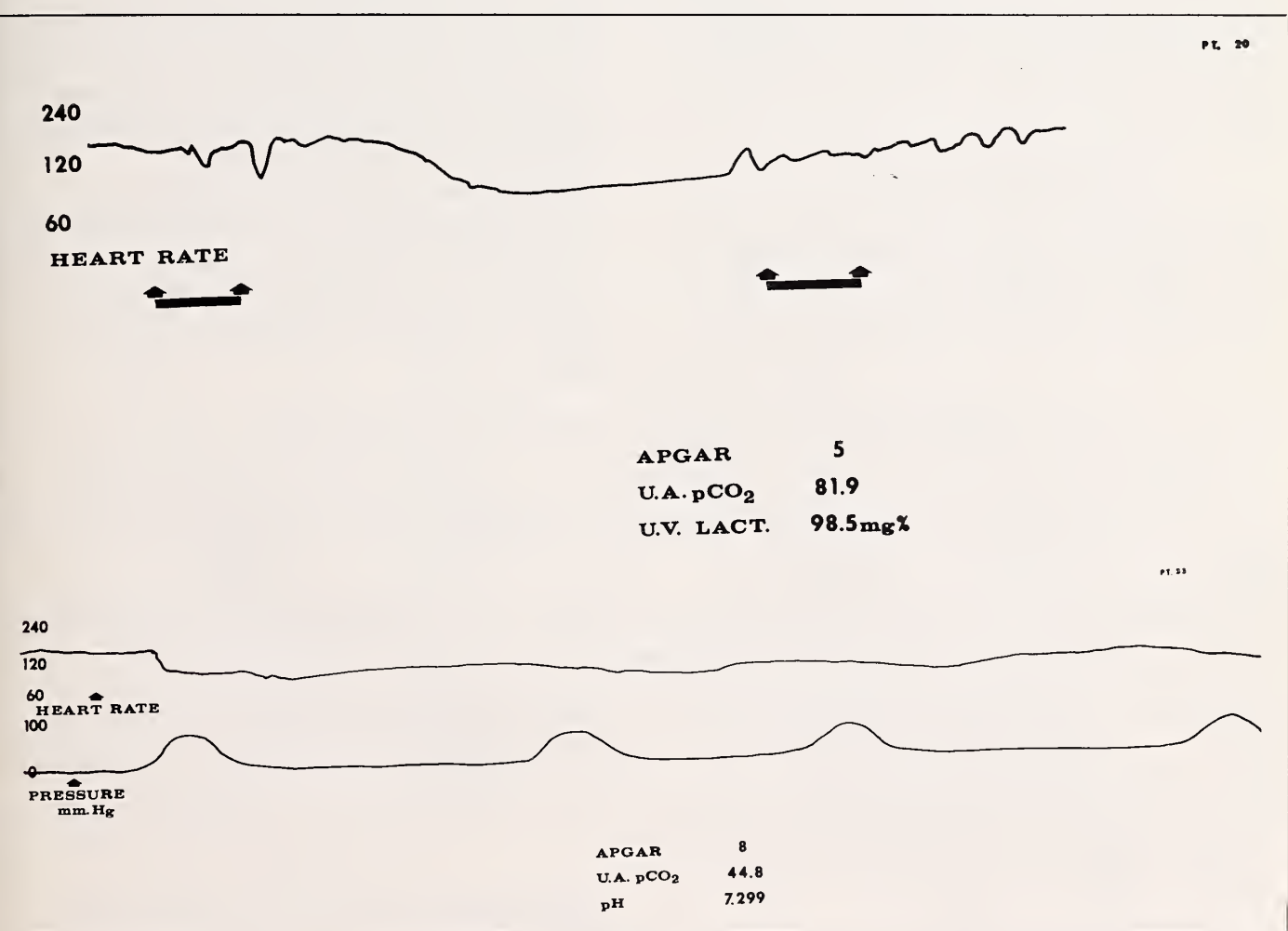


FIGURE 5

Bradycardia Occurring Throughout Uterine Contractions. Note the simultaneous pattern of fetal bradycardia occurring dur-  
ing multiple contractions, yet infant A is depressed and acidotic and infant B appears to be normal.

TABLE I  
VARIATION IN FETAL AID BASE BALANCE IN EUCARDIC AND TACHYCARDIC INFANTS

	Umbilical Artery				Umbilical Vein			
	PO2*	PCO2*	pH	Lactate+	PO2*	PCO2*	pH	Lactate+
Eucardia	18.6±5	51.3±9.2	7.29	24.5±6.8	30.9±8.3	41.7±10.1	7.35	17.9±3.5
Tachycardia	17.7±6.4	56.5±11.4	7.25	35.4±16.8	32.3±6.5	41.9±7.6	7.33	24.6±11.5

(Mean rate  
between contractions  
160 beats/min.)

\* Values in mm Hg.

± Values in mg %

Fetal bradycardia occurring only with uterine contractions has been termed vagal bradycardia. This is in many ways a correct but poor term. The implication is too often made that the vagal slowing of the heart is an etiology rather than a mechanism. This type of bradycardia occurs primarily with head compression and mild umbilical cord compression. The etiology of this type of bradycardia is (a) an increase in arterial pressure in the fetus activating baroreceptors or (b) a decrease in available tissue oxygen activating chemoreceptors. Current animal work would tend to implicate both factors; however, which is the primary etiology unsolved. We do have some evidence that the human fetus is slightly more acidotic when this type of bradycardia is present during labor. The umbilical arterial PCO<sub>2</sub> and pH is lower than in a control eucardic series (see Table II).

### Hypoxic Bradycardia

Fetal bradycardia in the absence of uterine contractions is felt to be one of the gravest prognostic signs for the fetus and has been termed hypoxic bradycardia. All current investigation would tend to indicate that lowered fetal oxygenation is usually

present in this type of bradycardia. The questions that must be asked are (1) How low are the oxygen values during this bradycardia, and (2) What oxygen values over what time span cause irreversible fetal damage? Both questions are exceptionally difficult and only by answering these questions will the true value of fetal heart rate be known. Preliminary work would seem to indicate that fetal bradycardia is concomitant with a decrease in oxygen tension rather than indicating absolute levels. This is demonstrated in Figure 5 showing two infants having similar patterns of bradycardia, one of whom was acidotic and depressed at birth and the other who had a normal acid base balance and was quite vigorous. The answer to question two, how long must the infant be hypoxic before damage is done, has been explored by Windle<sup>12</sup> in primates. He showed that brain damage occurred after seven to nine minutes of complete asphyxia.

Any discussion of fetal heart rate must inevitably lead to the management of the pregnancy in which the fetus shows changes in the heart rate. This fundamentally involves deciding whether a pregnancy should be terminated immediately. While many of the questions about fetal heart rate changes remain

TABLE II  
MEANS, STANDARD DEVIATIONS, AND "P" VALUES FOR GROUPS I AND II

	Umbilical Artery					
	PO2*	PCO2*	pH	Lactate+	Pyruvate+	
Group I	18.6±5	51.3±9.2	7.29	24.5±6.8	0.86±0.27	
Group II	16.1±3.9	56.8±7.3	7.25	33.1±12.9	0.71±0.15	
p values	NS.**	.10	.05	.10	N.S.	

	Umbilical Vein					
	PO2*	PCO2*	pH	Lactate+	Pyruvate+	
Group I	30.9±8.3	41.7±10.1	7.35	17.9±3.5	0.55±0.15	1.063±1.24
Group II	32.9±8.8	4.21±4.5	7.36	22.5±9.0	0.47±0.11	0.582±0.73
p values	N.S.	N.S.	N.S.	N.S.	N.S.	.01

\* Values in mm Hg.

+ Values in mg %

+ Values in m mole/l

\*\* N.S.=not significant

Group I are fetuses with no heart rate change in labor

Group II are fetuses showing a drop in heart rate with uterine contractions



unanswered, I think some tentative principles can be stated. First, fetal tachycardia in the absence of fetal bradycardia while perhaps indicating mild hypoxia and/or acidosis is well tolerated by the fetus. Likewise, fetal bradycardia starting early in the uterine contraction cycle and returning to a normal rate before uterine relaxation can simply be watched closely. Fetal bradycardia occurring in uterine diastole does indicate more serious difficulty. This does not mean that all fetuses showing this type of bradycardia should be delivered immediately. Here some clinical judgment must be employed. If the bradycardia is due to maternal hypotension as with conduction anesthesia or with too vigorous uterine stimulation by oxytocic drugs then that primary cause can be effectively changed and the fetus should progress uneventfully. If, however, the bradycardia is due to an uncorrectable cause such as maternal hypertension, toxemia of pregnancy, diabetes, or placental insufficiency, then the fetus should be delivered immediately.

### Monitoring Equipment

I would be remiss if I did not comment on the question—should every labor room be equipped with a fetal heart monitoring instrument? The instrument makers will obviously say, yes. At the present time my own feelings are somewhat negative in this area for several reasons. The primary reason is that while research in this area is proceeding rapidly, many questions remain unanswered which would give explicit criteria for early termination of the pregnancy. If all labors were monitored I am afraid the section rate would rise needlessly in many instances. Of secondary importance is the lack of

a reliable clinical instrument. Though there are many on the market at present, none are foolproof and fit the criteria of a sound clinical instrument. Most are still in the research and development stage.

### Summary

1. Some of the history of the development of fetal heart rate monitoring has been discussed.
2. The different patterns of fetal heart rate change have been presented.
3. A few tentative guidelines in the management of the fetus showing heart rate changes were indicated.

### Bibliography

1. Mayor: Quoted in *Bibliothèque Universale de Geneva*, vol. 9: 1818.
2. de Kegardec, L.: *Memoire sur l'auscultation Appliquée à l'étude de la Grossesse*, Paris, 1822.
3. Hon, E. H.: Electronic Evaluation of the Fetal Heart Rate, *Am. J. OB & GYN*, 75: 1215, 1958.
4. Cremer, M.: Über die direkte ableitung der aktions-tromme des menschlichen herzens vom oesophagus and uber das elektrokardiogramm des fetus, *Munchen Med. Wchnschr*, 53: 811, 1906.
5. Hellman, L.M.; Schiffer, M.A.; Kohl, S.G., and Tolles, W.E.: Studies in Fetal Well-being: Variations in Fetal Heart Rate, *Am. J. OB & GYN*, 76: 988, 1958.
6. Hon, E. H.: Instrumentation of Fetal Electrocardiography, *Science*, 125: 553, 1957.
7. Hon, E. H., and Hess, O. W.: The Clinical Value of Fetal Electrocardiography, *Am. J. OB & GYN*, 79: 1012, 1960.
8. Hunter, C. A., Jr.; Lansford, K. G.; Knoebel, S. B., and Braulin, R. J.: A Technique for Recording Fetal EKG During Labor and Delivery, *Obstet. & Gynec.*, 16: 567, 1960.
9. Calderyo-Barcia, et. al.: Effects of Abnormal Uterine Contractions on the Human Fetus, *Mod. Prob. Ped.*, 8:267, 1963.
10. Hon, E. H.: Observations on "Pathologic" Fetal Bradycardia, *Am. J. OB & GYN*, 77:1048, 1959.
11. Reynolds, S.M.R., and Paul, W. M.: Circulatory Responses of the Fetal Lamb in Utero to Increased Intrauterine Pressure, *Am. J. Physiol*, 193:249, 1958.
12. Wendle, W. F.: Neuropathology of Certain Forms of Mental Retardation, *Science*, 140:1186, 1963.

## 1965 CALENDAR OF MEETINGS

### State

- January 19-21, 1965—Electrocardiography Seminar sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.
- January 25-27, 1965—American College of Surgeons (sectional meeting) Atlanta Biltmore Hotel, Atlanta.
- February 13-14, 1965—Seminar on Arthritis, sponsored by the Georgia Chapter of the Arthritis Foundation, Academy of Medicine, Atlanta.
- February 15-17, 1965—Atlanta Graduate Medical Assembly, sponsored by the Fulton County Medical Society, Atlanta Biltmore Hotel, Atlanta.
- March 2-3, 1965—"Concepts of Fetal and Maternal Welfare," sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.
- March 31-April 2, 1965—"Problems in Gastroenterology," sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.
- May 2-4, 1965—111th Annual Session of the Medical Association of Georgia, Augusta.

### Regional

- January 21-23, 1965—Pediatric Seminar—"Current Concepts in Allergy and Clinical Immunology in Childhood," sponsored by the University of Florida College of Medicine, Gainesville, Fla.
- January 29-31, 1965—Southern Radiological Conference, Grand Hotel, Point Clear, Ala.
- February 13-17, 1965—American Academy of Allergy, Americana Hotel, Bal Harbour, Fla.

- February 19-24, 1965—American Society of Abdominal Surgeons, Jung Hotel, New Orleans, La.
- February 25-March 2, 1965—American Dermatological Association, Boca Raton Hotel, Boca Raton, Fla.
- February 26-28, 1965—Virginia Pediatric Society, The Greenbrier Hotel, White Sulphur Springs, W. Va.
- March 4-5, 1965—Obstetrics and Gynecology Seminar sponsored by the Division of Postgraduate Education of the University of Florida College of Medicine, Gainesville, Fla.
- March 8-11, 1965—New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La.
- March 22-24, 1965—Dallas Southern Clinical Society, Statler-Hilton Hotel, Dallas.
- March 23-26, 1965—National Society for Prevention of Blindness, Rice Hotel, Houston.
- March 25-27, 1965—Mid-Central States Orthopaedic Society, Velda Rose Motel, Hot Springs, Ark.
- March 26-27, 1965—National Conference on Rural Health (18th) Americana Hotel, Miami Beach.
- March 29-31, 1965—American Association for Thoracic Surgery, Roosevelt Hotel, New Orleans.

### National

- January 17-23, 1965—Eleventh Annual General Practice Review sponsored by the University of Colorado School of Medicine, Denver.
- June 20-24, 1965—American Medical Association, Americana Hotel, New York City.



# NEWER USES OF OLD DRUGS IN THE TREATMENT OF URINARY TRACT INFECTIONS

James O. Morse, M.D., Augusta

■ *Because of the difficulties encountered in the treatment of many urinary infections, this topic is worth re-emphasizing*

DESPITE the discovery of many valuable antimicrobial agents during the past 30 years, the practitioner of today is still faced at times with patients whose urinary tract infections present essentially the same problems as they did before the first sulfonamide drug was marketed. The problem of resistant organisms is, of course, not limited to infections of the urinary tract, but in some ways it seems more ubiquitous in that system. Whereas the patient with a serious systemic infection due to a resistant organism either recovers, using his own bodily defense mechanisms, or else succumbs fairly rapidly, the patient with a chronic urinary tract infection, whether treatable or not with sulfonamides or antibiotics, can be nearly asymptomatic for long periods only to be brought down years later by progressive renal failure. These latent cases provide a reservoir of problems in the community, awaiting discovery by the diligent physician.

## Chronic Pyelonephritis

Chronic pyelonephritis, even when caused by organisms sensitive *in vitro* to some antimicrobial agents, has proved itself stubbornly resistant to rapid cure, supposedly because the organisms are protected from adequate concentrations of antibiotics in the poorly perfused, scarred regions of the kidney. There has been some evidence that the prolonged administration of an antimicrobial agent which will at least suppress the bacteriuria may result in a cure of the pyelonephritis or at least slow the progression of renal damage.<sup>1</sup> Kass and associates have postulated that (1) "Chronic, active pyelonephritis results from the persistent reinfection of the kidney in consequence of continuous ascending spread of the bacteria from the urine into the renal parenchyma,"<sup>2</sup> and that (2) "The kidney and other tissues of the urinary tract tend to free themselves of infection spontaneously, unless continuously reinfected by the bacteria in the urine."<sup>3</sup>

Although a glance at the report of *in vitro* sensitivities may give momentary encouragement to the physician of the patient with chronic pyelonephritis,

closer study often brings forth feelings of frustration as he plans a course of therapy. The organism may be sensitive to kanamycin or colymycin, drugs which must be given parenterally and whose period of administration is definitely limited by their toxicity, particularly in the patient with some renal insufficiency. Chloramphenicol may occupy the sensitive column also, but lengthy administration brings the risk of depression of erythropoiesis. Although nitrofurantoin may be used in smaller doses in such a program of prolonged administration, the gastric and peripheral nerve intolerance experienced by some patients may force its discontinuance also. The expense of prolonged administration of standard-priced "broad-spectrum" antibiotics may be prohibitive for many patients. Then, the problem may be further magnified after a period of time by the appearance of organisms resistant to the formerly effective antibiotic.

Frequent recurrent acute urinary tract infections, particularly in patients with associated urological defects, may also make prolonged prophylactic administration of an antimicrobial agent desirable, but here again, in time one may find infections appearing with organisms resistant to the prophylactic drug.

## Forgotten in the Antibiotic Era

Problems such as these have driven some investigators in recent years to return to drugs which are now almost forgotten in the antibiotic era. Methylene blue had been tried and discarded in the past century as ineffective, but the first "break-through" in urinary antiseptics apparently came in 1894, when Nicolair in Germany first noted the effectiveness of methenamine.<sup>4</sup> The drug was soon promoted for use in systemic infections, but it was pointed out by 1913 that methenamine itself was not bactericidal but only useful in acid urine, where it releases formaldehyde. It was also shown by Shohl in 1920 that mere "acidity" was not sufficient for the efficient use of methenamine, that even at pH 6.4 only three per cent of the formaldehyde available was released by hydrolysis over 24-hours while at pH 5.0, 20 per cent was released.<sup>5</sup>

From the Department of Medicine, Medical College of Georgia and the Eugene Talmadge Memorial Hospital.



Various salts were tried during the following years in an effort to acidify adequately the urine; sodium acid phosphate, benzoic acid, ammonium benzoate, and ammonium chloride being the usual ones. All had the disadvantage of causing gastrointestinal intolerance in adequate doses. The ability of the ammonia mechanism of the kidney to compensate for the increased acid load and return the pH toward neutral after the first few days also frustrated efforts to maintain the desired pH 5.0 to 5.5.

In 1931 Helmholz, a pediatrician at the Mayo Clinic, noted that urine samples from epileptics on the ketogenic diet remained "unspoiled" for several days in the laboratory. Having found that obtaining the same urinary pH of 5.3 to 5.8 with acidifying salts did not render the urine bacteriostatic, he surmised that something other than just the acidity accounted for the bacteriostasis obtained with the ketogenic diet. He and Clark, a urologist, tried this method in several patients and obtained results which they considered superior to the previously used methenamine.<sup>7</sup> The popularity of this treatment was limited by the abhorrence of the patients for its rigid dietary demands. Beta-hydroxybutyric acid was later shown to be the effective agent in this treatment.

Mandelic acid was introduced in England in 1935 by Rosenheim who gave 12 gm. daily along with eight gm. of ammonium chloride in courses of ten to 21 days.<sup>8</sup> Apparently the relapses were treated in the same manner with no consideration being given to prolonged uninterrupted administration.

Another organic acid was found to be the effective agent in the home remedy used in some parts for dysuria. Cranberry juice in generous amounts provides enough hippuric acid to inhibit bacterial growth in urine.<sup>9</sup> The three organic acids, mandelic, hippuric, and beta-hydroxybutyric, found to be effective apparently act, not as mere acidifiers, but as bacteriostatic agents in their own right; however, they, like methenamine, work more effectively in an acid solution since it is probably only the unionized form which penetrates the cell wall.<sup>9</sup>

With the revival of interest in these old drugs brought about in recent years chiefly by Kass, he and other investigators have turned to seek more efficient means of acidifying the urine. Methenamine was compounded with mandelic acid (sold as Mandelamine) some years ago, and this drug alone is capable of lowering the pH of the urine in some patients if used in large enough doses and provided no urea-splitting organisms are present. The small amount of mandelic acid present is not thought to contribute much to the bactericidal effect and, when

used in doses of 6.0 gm. per day, frequency and burning on urination are common complaints.<sup>10</sup>

### **Methionine Tried**

Since it had been shown that dietary sulfur accounted for the major portion of the urinary acid output in man, methionine, a sulfur-containing amino acid, was tried. About 70 per cent of the administered dose was found to be metabolized to sulfate accompanied by equivalent quantities of protons which ultimately were excreted in the urine.<sup>12</sup> A dose of 13.9 gm. per day for five or six days lowered the serum CO<sub>2</sub> content slightly but without any change in blood pH. There was a fall in urine pH and an increase in ammonia excretion; however, the urine pH did not rise with continued administration of methionine as it did with equivalent amounts of ammonium chloride.<sup>13</sup> Why there should be this difference in the effects of the two drugs has apparently not been explained as yet.

Methionine alone in doses of 12 to 15 gm. per day was found to give a urine pH of 4.5 to 5.0 and to reduce colony counts 1000 fold.<sup>14</sup> Others have reported that much smaller doses of 0.6 gm. per day are effective in controlling odor, dermatitis, and ulceration from ammoniacal urine in incontinent mental patients; however, no bacteriological studies were done to determine the mechanism of this effect.<sup>15</sup> Others have shown that, apart from its acidifying effect, methionine has no in vitro antibacterial activity.<sup>16</sup>

### **Kass Recommends**

Kass recommends using methionine as the bulk powder mixed with fruit juice or flavoring, beginning with 8.0 gm. per day and increasing the daily dose by 2.0 gm. every three days or more to maintain the urinary pH 5.0 or less as checked by the patient with Nitrazine paper. Methenamine mandelate may be begun at the same time in doses of 2.0 gm. per day. If bacteriuria has not been suppressed after 72-hours, then the daily dose should be increased by 2.0 gm. It may be further increased to 6.0 gm. per day if necessary, but after the bacteriuria has cleared the dose should be decreased 1.0 gm. each day until any dysuria is relieved but the pathogens are still inhibited. No organism was found resistant to this combination provided the desired acidity could be attained. Members of the *Klebsiella-Aerobacter* group required slightly higher concentrations of all organic acids tried than did the other Gram-negative rods, but the difference was at most two-fold. Most failures were due to the proteus organisms since their urea-splitting activities often made it impossible to increase the acidity sufficiently.



## URINARY TRACT INFECTIONS / Morse

Kass admits that complete cures, even with prolonged treatment, are not the usual results, although he feels that bacterial suppression makes continued administration of the drugs worthwhile even in the incurable cases. He cites some remarkable cases such as that of a child of six years with a two year history of rebellious infection.<sup>2</sup> After nine months of continued drug therapy the urine remained sterile for an additional year, then after one month of treatment of the relapse, the urine had remained sterile to the time of the report over 18 months later. A 23-year-old male with a five year history of almost continuous dysuria responded to two months of drug administration, and sterile cultures were still found more than two years later.

### Far From Ideal

Methionine is still far from being an ideal urinary acidifier, its most disagreeable property for many patients being the odor imparted to the breath, similar to that of patients with hepatic failure.<sup>12</sup> Cerebellar ataxia has been noted in a few children on large doses.<sup>17</sup>

Ascorbic acid was suggested as a urinary acidifier because of its low renal threshold, lack of toxicity, pleasant taste, and low cost. A study using catheterized adults with chronic urinary tract infection showed that on doses of 2.5 gm. daily an average pH of 5.3 was obtained within the first 24-hours of administration.<sup>16</sup>

A recent clinical study has utilized ascorbic acid as the acidifying agent along with methenamine mandelate in an attempt to prevent recurrent urinary tract infections in girls.<sup>17</sup> Methenamine mandelate was given in divided doses of 2.0 gm. per square meter per day and ascorbic acid three or four times a day in total doses of 0.5 to 1.5 gm. per day to keep the urine pH 5.5 or below. Existing urinary infection was first eradicated with appropriate drugs before beginning the prophylaxis. Infections were reduced in frequency from an average of one every 2.6 months to one every 15 months, and eight out of the 20 had developed no more positive cultures during the average two and one-fourth years they were studied.

Despite these encouraging results, urinary antiseptics are far from solving all the problems of chronic pyelonephritis. It is dangerous to administer acidifying agents to patients already in acidosis from renal failure, and this restriction eliminates many patients who need the therapy the most. Unless urea-splitting organisms respond sufficiently to the initial administration of some antibiotic to enable the acidifying agent to lower the pH to the range of efficient hydrolysis of methenamine, these in-

fections are beyond help. There is some evidence that in rats, at least, the administration of ammonium chloride and presumably any acidifying salt increases the susceptibility of the kidney to intravenously injected *Escherichia coli*.<sup>18</sup> It is postulated that the increased ammonia formation in the kidney inactivates compliment and thus renders the organ more susceptible to certain kinds of infection.

### Conclusions

It presently appears that the most desirable regimen for the management of the chronic or recurrent urinary tract infection due to organisms resistant to the practical antibiotics or chemotherapeutic agents is the use of sufficient ascorbic acid to keep the urinary pH in the range 5.0 to 5.5 together with sufficient methenamine, or methenamine mandelate, to suppress the bacteriuria. Study is needed to determine whether or not methenamine alone can be used safely and effectively in the presence of chronic renal insufficiency when the urinary pH may already be in the desirable range. It is hoped that similar drugs effective in an alkaline urine can be developed for use against urea-splitting organisms and in cases of cysteine or uric acid stone formers in whom continued alkalinization of the urine is desirable.

No matter which agent is selected for the treatment of the urinary tract infection, the physician should realize that only by careful follow-up can the length of treatment needed be determined. It should be re-emphasized that symptom-free often does not mean infection-free when dealing with the urinary tract. A false security assumed by the patient and his doctor may be the major cause of the development of renal failure in chronic pyelonephritis.

### Summary

The problem of resistant organisms, intolerance to drugs, and expensive antibiotics has complicated the treatment of chronic or recurrent urinary tract infections. Some organic acids and methenamine, both of which were used to treat these infections prior to the antibiotic era, are now finding a larger place in the modern armamentarium. More efficient urinary acidifying agents have increased the effectiveness of these urinary antiseptics.

The necessity for careful follow-up and long-term treatment in many cases of urinary tract infection is emphasized.

### Bibliography

1. Jawetz, E.; Hopper, J. Jr., and Smith, D. R.: Nitrofurantoin in Chronic Urinary Tract Infections, *Arch. Int. Med.*, 100:549 (Oct.) 1957.
2. Zangwill, D. P.; Potter, P. J.; Kaitz, A. L.; Cotran, R. S.; Bodel, P. T., and Kass, E. H.: Antibacterial Organic Acids in Chronic Urinary Tract Infection, *Arch. Int. Med.*, 110:801 (Nov.) 1962.
3. Kass, E. H. and Zangwill, D. P.: Principles in the Long-Term Management of Chronic Infection of the Urinary Tract, p. 663. In Juinn, E. L. and Kass, E. H.



(Ed.), *Biology of Pyelonephritis* Boston. Little, Brown, and Co., 1960.

4. Nicolaier, A.: *Deutsch Med. Wchnschr.* 34:541, 1895 as cited in Hanzlik, P. J. and Collins, R. J.: Hexamethylenamin: The Liberation of Formaldehyde and the Antiseptic Efficiency under Different Chemical and Biological Conditions, *Arch. Int. Med.*, 12:578 (Nov.) 1913.

5. Shol, A. T. and Deming, C. L.: Hexamethylenamin: Its Quantitative Factors in Therapy, *J. Urol.*, 4:419 (Oct.) 1920.

6. Helmholtz, H. F.: The Ketogenic Diet in the Treatment of Pyuria of Children with Anomalies of the Urinary Tract, *Proc. Staff Meet. Mayo Clinic*, 6:609 (Oct. 14) 1931.

7. Clark, A. L.: *Escherichia Coli* Bacilluria under Ketogenic Treatment, *Proc. Staff Meet. Mayo Clinic*, 6:605 (Oct. 14) 1931.

8. Rosenheim, M. L.: Mandelic Acid in the Treatment of Urinary Infections, *Lancet*, 1:1032 (May 4) 1935.

9. Bodel, P. T. Cotran, R. and Kass, E. H.: Cranberry Juice and the Antibacterial Action of Hippuric Acid, *J. Lab. and Clin. Med.*, 54:881 (Dec.) 1959.

10. Knight, V.; Draper, J. W.; Brady, E. A., and Atmore, C. A.: Methenamine Mandelate: Antimicrobial Activity, Absorption, and Excretion, *Antibiotics and Chemotherapy*, 2:615 (Dec.) 1952.

11. Hunt, J. N.: The Influence of Dietary Sulphur on

the Urinary Output of Acid in Man, *Clinical Science*, 15:119 (Feb.) 1956.

12. Lehmann, J. Jr. and Relman, A. S.: The Relation of Sulfur Metabolism to Acid-Base Balance and Electrolyte Excretion: The Effects of DL-Methionine in Normal Man, *J. Clin. Invest.*, 38:2215 (Dec.) 1959.

13. Unpublished studies of E. H. Kass, referred to by Lehmann.<sup>12</sup>

14. Kass, E. H.: Bacteriuria and the Diagnosis of Infections of the Urinary Tract. With Observations on the Use of Methionine as a Urinary Antiseptic, *Arch. Int. Med.*, 100:709 (Nov.) 1957.

15. Bergman, M.: Control of Odor, Dermatitis, and Ulceration from Ammoniacal Urine with dl-Methionine, *Geriatrics*, 12:386 (June) 1957.

16. McDonald, D. F. and Murphy, G. P.: Bacteriostatic and Acidifying Effects of Methionine, Hydrolyzed Casein, and Ascorbic Acid on the Urine, *New. Eng. J. Med.*, 261:803 (Oct. 15) 1959.

17. Holland, N. H. and West, C. D.: Prevention of Recurrent Urinary Tract Infections in Girls, *Am. J. Dis. Child.*, 105:560 (June) 1963.

18. Freedman, L. F.: The Effect of an Acidifying Salt on the Susceptibility of the Kidney to Infection, p. 433. In Quinn, E. L. and Kass, E. H. (Ed.), *Biology of Pyelonephritis*. Boston. Little, Brown, and Co. 1960.

## SUMMARY OF RECENT MAG COUNCIL AND EXECUTIVE COMMITTEE ACTIONS

(The full minutes from which these summaries have been abstracted are available to any MAG member upon request to the Journal)

### MAG Mental Health Sub-committee Inter-Agency Meeting November 1, 1964

For Criteria of Indigency for Community Mental Health Centers: Dr. Stribling, Chairman of the Mental Health Sub-committee, reviewed the problem and suggested a discussion of the criteria of certification of patients for treatment, noting the difference between psychiatric and non-psychiatric indigent patients.

Various points highlighted: (1) that income alone should not be a criterion for help; (2) A. E. Hauck reported on the progress of the report on this problem, the report to be finished by the end of the year; (3) it was suggested that other state plans be studied for comparison; (4) Dr. Hauck was asked to have his committee formulate a tentative plan with criteria on which to base eligibility of patients for psychiatric care; (5) Dr. Hall was asked to get ideas from the Georgia Psychiatric Association on how they might solve this problem; (6) Agreed that group would meet again to discuss progress being made.

### Executive Committee of Council/November 22, 1964

Change made in minutes of October 3, 1964, regarding "Redistricting of Councilor Districts." The sentence in the paragraph should read:

"On amended motion to the above motion (Alexander-McDaniel) it was voted to recommend that the House of Delegates delegate authority to Council to approve the new district societies as they are set up prior to the 1966 Annual Session."

The minutes were then approved with the change as indicated above.

Report received: Dr. Bishop outlined proposed program for 1965 County Society Leadership Conference. Executive Committee approved idea, but asked Dr. Bishop to reconsider certain aspects.

Treasurer's Report received: Report was approved. Dr. Atwater asked approval of transference of \$500 from the contingent fund to cover overage on postage; report was granted.

Medicare report received: Voted to ask Medicare Review Board to make immediate changes for 1965, with complete revision to be made next year.

VA Fees for Treatment of Service Connected Disabilities Outside VA Facilities: It was recommended that the 1960 California Relative Value Study, as modified by the VA, is acceptable to the Medical Association of Georgia.

Reinvestigation of the use of OAA Funds in Georgia: Executive Committee agreed that the MAG Cancer Committee and the Department of Health meet to make recommendations concerning the use of OAA Funds for patients over 65 now re-

ceiving state services covered by the OAA Funds.

Committee appointments:

(1) Mental Health Subcommittee: Thomas M. Hall, Macon

(2) Public Service Information Clearing House Subcommittee: This committee has not functioned since organization and W. D. Stribling, Gainesville, asked to be relieved as Chairman. The Executive Committee approved his request.

(3) Interprofessional Council: C. Daniel Cabaniss, Atlanta, with term to expire in 1967.

Mr. Krueger discussed the following items: (1) AMA Judicial Council Opinions to be mailed to all MAG members, the method to be determined; (2) Personnel; (3) Purchase of Xerox machine deferred for investigation; and (4) Suggested that the January Executive Committee meeting be held at Callaway Gardens at the time of the Medical Education Conference. The Executive Committee approved this suggestion and January 29, 1965, at 2:00 p.m., Holiday Inn, Callaway Gardens, was agreed upon.

Private Patient Care at MCG: Dr. Mauldin stated that there is no truth in the rumor that a private patient care clinic was being opened.

Visitation with Governor: Dr. Mauldin was asked to make an appointment with the Governor.

Site of 1967 MAG Annual Session: Mr. Krueger asked that the Marriott Hotel in Atlanta be considered as the site of the 1967 Annual Session; it was voted to make the commitment with the hotel.

Health Opportunity Program for Elderly Ad: The Bulloch-Chandler-Evans Medical Society asked approval of a change in an MAG informational sheet to be published in three newspapers with the addition of a paragraph to explain the information. Executive Committee approved the publication of this information and Dr. Mauldin was asked to contact the MAG attorney regarding the legality and then to inform the county society.

Ad Hoc Nursing Home Study Committee: Dr. Atwater reported that the MAG Ad Hoc Nursing Home Study Committee had met. A report of their recommendations will be made in December.

Additional MAG Delegates to AMA: MAG will qualify for additional AMA delegate, term to begin January, 1965, but who cannot be elected until Annual Session, May, 1965.

As Dr. Mauldin was not able to attend the AMA Miami Area-wide Planning Meeting, he recommended that Dr. Napier Burson, Atlanta, attend; voted to ask Dr. Burson to represent MAG, expenses to be paid from office travel, and that Dr. Burson report back to Executive Committee about the meeting.

Fulton County Medical Society's Recommendation on Alcoholism: Recommended deferral, since MAG is making recommendations regarding public safety.



# IRON LOADING ANEMIA

H. Chan. White, Jr., M.D., *Macon*

■ *The anemia is usually moderate but may be as low as six grams of hemoglobin*

**T**HIS TITLE is a little unusual but is a relatively new concept in hypochromic anemias. As you know, the differential diagnosis of hypochromic anemia includes iron deficiency, Pyridoxine responsive, Thalassemia, lead poisoning, and even chronic infection, rheumatoid arthritis, and Hodgkins disease. Included in this now are the iron loading syndromes; the best known being hemochromatosis.

## Variety of Names

A syndrome which may have a similar pathophysiology to Pyridoxine responsive anemias has been given a variety of names including Hereditary Sex Linked Anemia. As the name implies, the syndrome, except rarely, is familial and seems to be a recessive gene transmitted through the female. In contrast to hemochromatosis there is a chronic refractory anemia which may begin in childhood and be fairly well tolerated. The erythrocytes show anisocytosis and poikilocytosis along the hypochromia. The reticulocyte count is not elevated and no siderocytes are present in the peripheral blood. Serum Iron is elevated to 300 mgm. per cent or more with the upper limit of normal around 160 mgm. per cent. This results also in a high per cent saturation of the total iron binding capacity. Females in families that have been studied have hypochromic red cells but no anemia. On physical examination hepatosplenomegaly is noted with a few of the patients being stunted in growth.

No relation has been found with Thalassemia as there is no increase in fetal or A2 hemoglobin. Electrophoresis has revealed no abnormal hemoglobins and also in contrast to Thalassemia there is a normal red cell count.

With the finding of an elevated serum iron, iron ( $\text{Fe}^{59}$ ) studies have shown a rapid plasma clearance as well as a decreased iron utilization. Red cell survival studies ( $\text{Cr}^{51}$ ) have shown the life span

to be reduced to as much as one-half along with some increase in the indirect serum bilirubin. Osmotic fragility studies have been normal or have shown a wider range of hemolysis than controls.

Bone marrow examination reveals erythroid hyperplasia of the normoblastic type but in these cases the erythropoiesis is ineffective. Even though hemosiderin is present in large amounts, the marrow is able to respond only to a half the maximum output when the anemia worsens. The anemia is usually of moderate degree but may be as low as six gms. of hemoglobin.

## Progression of Signs

Following these patients clinically and with serial liver biopsies, there has been found a steady progression of the signs and symptoms of hemochromatosis. Included is the development of increased skin pigmentation, diabetes, congestive heart failure, cardiac arrhythmias and ascites. Pathological examination of the spleen shows hemosiderosis of excessive amounts and fibrosis. The liver has increasing amounts of parenchymal hemosiderosis and increasing portal fibrosis while the pancreas shows these same lesions. Examination of the heart likewise shows fibrosis and increased amounts of iron.

As mentioned above this is progressive and is what incapacitates and eventually kills the patient. Little or no complications of the diabetes are noted.

## The Occurrence

Why then does the development of iron overload occur even when there is no history of excessive blood transfusions or oral iron therapy? The earlier theory of iron absorption in short is that with the entry of oral iron into the mucosa it stimulates the formation of apoferritin which then combines to form ferritin and the iron is later absorbed into the blood stream. The ferritin then prevents the excessive absorption of intestinal iron which is called the mucosal block theory. This is not exactly correct

Presented at the 110th Annual Session of the Medical Association of Georgia, May 4, 1964, Macon, Georgia.



as iron may not be released from the ferritin but stored especially in iron overload syndromes. There appears to be a sustained absorption of iron until the plasma level has reached a maximal point. The important regulatory mechanism in normal individuals is the size of the body stores of iron and the rate of erythropoiesis. For example, in anemic patients with a hypocellular marrow, iron absorption is markedly depressed, and in primary hemochromatosis iron absorption slows down as the body stores increase but this is not related to the saturation of serum transferrin.

### **A New Concept**

Dr. Crosby, who is an authority on iron metabolism, and co-workers at Walter Reed Hospital have done recent work in regard to this. In their new concept, the columnar cells of the small intestine on forming use intrinsic iron to form ferritin with the amount of ferritin depending on the total body iron stores present. This iron is permanently held in the cell and the amount absorbed from the intestine depends on the amount of ferritin originally present. This is called reverse loading and some of the oral iron that is absorbed goes into the body while the remainder completes the saturation of the ferritin mechanism in the cell. As the life span of the cell is only several days, this also serves as a mechanism for the removal of excessive iron from the body. Also, in iron storage diseases, tissue macrophages accumulate intrinsic iron and by diapedesis carry some of the unneeded iron into the feces, urine, and even sputum. The columnar cells of the intestine in iron overload patients also accumulate non-functional iron, so on normal desquamation serve as another source of body iron loss.

### **Pyridoxine Administration**

Many reports have appeared in the literature concerning anemia which have hypochromic red cells which have responded to pyridoxine administration. These patients have a normoblastic erythroid hyperplasia of the marrow with an elevated serum iron and a high per cent saturation of the total iron binding capacity. The anemia is also slowly progressive and may reach moderate to severe proportions. With pyridoxine deficiency there has been found an increased iron absorption from the intestine. In these cases, half of the patients ultimately develop hemochromatosis. As a result of the closeness of the overall clinical and pathological picture with Hereditary Hypochromic Anemia, just what may be the mechanism of the disease process? First, several of the pyridoxine responsive patients showed no evidence of pyridoxine deficiency with the use of the tryptophane tolerance test. This

amino acid is dependent on pyridoxine for its metabolism and with a deficiency intermediate metabolites such as Xanthurenic Acid appear in the urine. Others, however, have shown abnormalities in tryptophane metabolism which have been corrected by pyridoxine. The dose used in treating these patients has been 200 mgs. intramuscularly a day. When a response is obtained, the reticulocyte count rises as early as the seventh day; the same as occurs in the treatment of iron, Vitamin B<sub>12</sub>, and Folic Acid deficient anemias. Most responses are only partial but even if they show a good response will relapse when therapy is discontinued. This, of course, does not suggest a deficiency, as the minimum daily requirement of pyridoxine, although not known, is around one mg. per day. A possibility of saturating a biochemical step in the metabolism of hemoglobin is suggested. For example, it is believed that this particular step is associated in the formation of porphyrins for the production of hemoglobin. Early in the biochemistry of hemoglobin is the formation of delta amino levulinic acid which is formed from Succinyl Coenzyme A and Glycine-Pyridoxal 5 phosphate. In the formation of Glycine Pyridoxal phosphate, pyridoxine with either a Kinase or Oxidase enzyme becomes Pyridoxal 5 phosphate. In pyridoxine responsive anemia, it is believed that there is a lack of the Kinase or Oxidase enzyme and therefore, a defect in the formation of hemoglobin. With large doses of pyridoxine an alternate pathway is used, or the large amount can partially overcome the defect.

In Hereditary Hypochromic Anemia the defect is felt to be related to a sex linked recessive gene resulting in an enzyme block so that the red cell is not able to use the iron and porphyrins in the formation of hemoglobin. This results therefore, in a hypochromic anemia and excessive iron absorption resulting in excessive total body stores. The iron may then in turn form an iron pyridoxine complex which in turn inhibits the formation of delta amino levulinic acid resulting in the clinical similarity of these two diseases.

### **Primary Hemochromatosis**

Primary Hemochromatosis, another disease of iron loading, is thought to be an inborn error of metabolism which may be familial and may be an autosomal dominant gene with incomplete penetrance or a recessive gene. It has been suggested that the defect is related to the reverse loading theory as mentioned above. A loss of ability to form ferritin from intrinsic iron occurs and results in an increase in intestinal iron absorption. The overall rate of absorption depends also on the iron excretory system. Patients with hemochromatosis have been



## ANEMIA / White

found to absorb up to five mg. of iron a day from a normal diet containing an average of 15 mg. of iron. In rare cases anemia is present in hemochromatosis. With the extra 20 to 40 gms. of body iron pyridoxine complex may form resulting in the biochemical defect as noted in the other syndromes.

Under the classification of Exogenous Hemochromatosis comes the refractory anemias such as Thalassemia major, Aplastic, Sickle cell, and even Acquired Hemolytic Anemias. Patients with these diseases who have received large amounts of oral iron and/or large numbers of blood transfusions, usually over a hundred units, may develop hemochromatosis with its complications if they live. Usually due to their short life span, they develop only hemosiderosis and have no difficulty from the excess iron they have received.

### Treatment A Problem

Treatment in these diseases is always a problem. In pyridoxine responsive anemia, pyridoxine does

not seem to be the complete answer due to their uniform relapse or their poor response. In hereditary sex linked anemia, these patients have not responded to any medication. As the pathophysiology of these diseases is very similar to hemochromatosis, regular phlebotomies may aid the patient from becoming debilitated. It may even improve the anemia when excessive iron has been removed as has been found in Hypochromic Iron Loading Anemia. Iron was found to go into the formation of hemoglobin and the marrow to become more efficient after a series of phlebotomies.

In secondary hemochromatosis, however, phlebotomies are of course contraindicated. A relative new iron chelating agent Desferrioxamine B may be the answer for removing the excessive body iron. It may also play a part in the treatment of these other diseases which have been discussed as one molecule of Desferrioxamine B combined with three moles of Ferric Iron ( $\text{Fe}^{+++}$ ). It has a greater affinity for iron than other metals and does not deplete the body of Magnesium, Calcium or Copper. Desferrioxamine B may even remove iron bound

the most widely  
prescribed  
peripheral  
vasodilator...

**ARLIDIN**  
(NYLIDRIN HCl)  
increases  
blood flow...



### IN CEREBROVASCULAR INSUFFICIENCY

where vascular insufficiency  
may cause such symptoms  
as mental confusion, diplopia,  
fatigue, apathy, and behavior  
problems.



### IN PERIPHERAL VASCULAR DISEASES

where ischemia causes muscle  
distress—pain, spasm, ache,  
intermittent claudication; also  
coldness, numbness or  
ulceration of extremities.



to transferrin. No toxic effects have been noted from the drug even after therapy for 16 months. A big drawback is that it has to be given intramuscularly. To begin, the dose of 400 mg. three times a day is used with a single daily injection for maintenance. The results are directly related to the dose given and as much as 40 mgs. of iron per 24 hours have been excreted into the urine. Patients with primary and secondary hemochromatosis have shown improvement including their associated anemia.

With phlebotomies, Desferrioxamine B and even Pyridoxine, the clinician will be fairly well armed to care for these patients.

724 Hemlock Street

#### Bibliography

1. Gelpi, A. P., and Ende, N.: An Hereditary Anemia with Hemochromatosis, *A. J. M.*, 25:303,314, 1958.
2. Crosby, W. H., and Sheehy, T. W.: Hypochromic Iron Loading Anemia, *Brit. J. Hem.*, 6:56-65, 1960.
3. Crosby, W. H.: Treatment of Hemochromatosis by Energetic Phlebotomy, *B. J. H.*, 4:82-88, 1958.
4. Verloop, M. C., and Rademaker, W.: Anemia Due to Pyridoxine Deficiency in Man, *B. J. H.*, 6:66-79, 1960.
5. Byrd, R. B., and Cooper, T.: Hereditary Iron Loading

Anemia with Secondary Hemochromatosis, *Annals of Int. Med.*, 55:103-123, 1961.

6. Bottomly, S. S.: Pyridoxine Responsive Anemia, *J. A. M. A.*, 180:653-659, 1962.

7. Bishop, R. C., and Bethell, F. H.: Hereditary Hypochromic Anemia with Transfusion Hemosiderosis Treated with Pyridoxine, *N. E. J. M.*, 261:486-489, 1959.

8. Rundles, W.: Hereditary Sex Linked Anemia, *Am. J. Med. Sc.*, 211:641-658, 1946.

9. Weisman, H.: Hypochromic Anemia with Hyperferricemia Responding to Oral Crude Liver Extract, *A. J. M.*, 22:99-106, 1957.

10. Castle, W. B. and Ersley, A. J.: Pyridoxine Responsive Anemia, *N. E. J. M.*, 262:1209-1214, 1960.

11. Moeschlin, S., and Schnider, U.: Treatment of Primary and Secondary Hemochromatosis and Acute Iron Poisoning with a New Potent Iron Eliminating Agent, *N. E. J. M.*, 269:57-66, 1963.

12. Conrad, M. E., Jr., and Crosby, W. H.: Intestinal Mucosal Mechanisms Controlling Iron Absorption, *Blood*, 22, 406-415, 1963.

13. Wheby, M. S. and Crosby, W. H.: The Gastrointestinal Tract and Iron Absorption, *Blood*, 22, 416-428, 1963.

14. Crosby, W. H. and et al: The Rate of Iron Accumulation in Iron Storage Disease, *Blood*, 22, 429-440, 1963.

15. Crosby, W. H.: Editorial Review, *Blood*, 22, 441-449, 1963.

16. Harrison, *Principles of Internal Medicine*: New York, N. Y.—McGraw Hill Book Company, 1962.

17. Bothwell, T. H., and Finch, C. A., *Iron Metabolism*: Boston, Mass. Little, Brown and Company, 1962.



## IN CIRCULATORY DISORDERS OF THE INNER EAR

where decreased blood flow results in hearing loss (sudden onset), tinnitus, and vertigo.

VASODILATIVE / VASORELAXANT

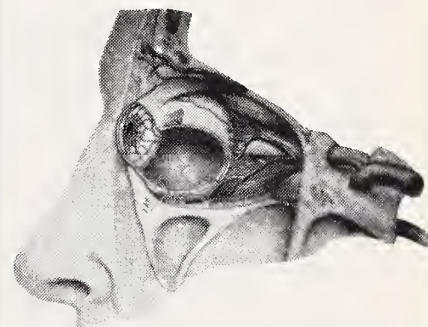
# ARLIDIN® (NYLIDRIN HCl)

decreases resistance in arteries and arterioles in skeletal muscle, in the brain, and possibly in the eye and inner ear • increases cardiac output (minute stroke volume) without significant changes in pulse rate or blood pressure • especially useful in enhancing blood flow in ischemic tissues • essentially safe, well tolerated, with rapid and sustained response • economical

side effect: Occasional palpitation. precautions: Use with caution in the presence of a recent myocardial lesion, paroxysmal tachycardia, severe angina pectoris and thyrotoxicosis. contraindication: Acute myocardial infarction.

**u. s. vitamin & pharmaceutical corp.**

800 Second Ave., New York, N. Y. 10017



## IN CIRCULATORY DISORDERS OF THE EYE

where there is vasospasm and circulatory impairment.

Available in 6 mg. scored tablets, and 5 mg. per cc. parenteral solution.



# WHEN DOES PREGNANCY TEST BECOME NEGATIVE AFTER NORMAL DELIVERY, INCOMPLETE ABORTION AND MISSED ABORTION ?

D. Frank Mullins, Jr., M.D.; Lewis R. Collins, M.D., and  
John R. Clark, M.D., *Augusta*

## ■ *Advantages and limitations of the toad test are discussed.*

SEVERAL YEARS ago the senior author of this paper was embarrassed to admit that he did not know the answer to the simple question: When do Pregnancy Tests become negative after normal delivery, incomplete abortion and missed abortion? Medical literature review revealed no current references, although numerous references regarding various methods for detecting early pregnancy are reported in endocrinology, gynecology and pathology journals.

Patients from the Eugene Talmadge Memorial Hospital, the University Hospital, and physicians in private practice contributed four samples of blood for this study. They were contributed at the time of delivery or abortion, one hour after delivery or curettage.

When the patient was admitted for incomplete or missed abortion, the first sample was obtained as soon as possible.

The method consisted of injecting two cc of serum drawn off clotted blood into the dorsal lymph sac of the male toad. After a period of two to three hours, urine was removed from the cloaca by means of a capillary pipette and examined under the microscope. The presence of sperm constitutes a positive test. If, at the end of four hours, no spermatozoa had appeared in the urine the test was considered negative. In our study we found the toads to be as responsive to serum as urine. Serum is preferred because of its ease of collection and storage, decreased toxicity, and elimination of

urine concentration techniques. During the summer months the toad was used because it does not show the seasonal variation in response to chorionic Gonadotropin as seen in the various species of *Rana Pipiens*. We encountered no false-positives or false-negative reactions using the toad.

*Results:* The results of the tests are tabulated in the Table on the following page.

Our results bear out the observations of Bradbury and Brown, who report that after the loss of the placental source of Chorionic Gonadotropic Hormone, several days are required for the elimination of the substance from the bloodstream. In our experiment we have evaluated a number of normal delivery cases who served as control. Ten out of fifteen or 66.6 per cent of these cases gave positive pregnancy tests one hour post-partum, but gave negative pregnancy tests twenty-four hours post-partum. Five out of fifteen, or 33.3 per cent were positive 24 hours post-partum but were negative at forty-eight hour period. Once the test became negative they did not revert to positive.

Three cases of incomplete abortion, 100 per cent, gave positive pregnancy tests twenty-four hours post-partum but were all negative at 48 hours. In missed abortion all tests were persistently negative. In our single case of ruptured tubal pregnancy the control sample taken before operation was positive and the sample one hour after operation was positive. The pregnancy test was negative two hours after operation.

Our observations indicate that the male toad pregnancy test is a valuable, reliable test animal



Patient	Type Pregnancy	Control	One hr. PP	24 hr. PP	48 hr. PP
Adams	Incomplete Abortion	Positive	Positive	Positive	Negative
Fountain	Incomplete Abortion	Positive	Positive	Positive	Negative
Galloway	Incomplete Abortion	Positive	Positive	Positive	Negative
Barfield	Missed Abortion	Negative	Negative	Negative	Negative
King	Missed Abortion	Negative	Negative	Negative	Negative
McDuffie	Missed Abortion	Negative	Negative	Negative	Negative
Mincey	Tubal Pregnancy	Positive	Positive	Negative	Negative
Bennett	Normal Pregnancy	Positive	Positive	Negative	Negative
Berry	Normal Pregnancy	Positive	Positive	Negative	Negative
Chalker	Normal Pregnancy	Positive	Positive	Negative	Negative
Coleman	Normal Pregnancy	Positive	Positive	Negative	Negative
Collier	Normal Pregnancy	Positive	Positive	Negative	Negative
Ferrell	Normal Pregnancy	Positive	Positive	Negative	Negative
Morgan	Normal Pregnancy	Positive	Positive	Negative	Negative
Neal	Normal Pregnancy	Positive	Positive	Negative	Negative
Screws	Normal Pregnancy	Positive	Positive	Negative	Negative
Waltower	Normal Pregnancy	Positive	Positive	Negative	Negative
Hall	Normal Pregnancy	Positive	Positive	Positive	Negative
Hammond	Normal Pregnancy	Positive	Positive	Positive	Negative
Lamar	Normal Pregnancy	Positive	Positive	Positive	Negative
Luke	Normal Pregnancy	Positive	Positive	Positive	Negative
McCannon	Normal Pregnancy	Positive	Positive	Positive	Negative

in determining the presence of viable chorionic villi. The pregnancy test is negative 24 hours after delivery; the pregnancy test is positive 24 hours after incomplete abortion. The pregnancy test is negative

48 hours after incomplete abortion. Missed abortion patients gave negative tests throughout the entire series.

1467 Harper Street

### AMA PRESENTS SERIES OF POSTERS AND PAMPHLETS FOR HARD-HITTING HINTS TO A HEALTHIER, SAFER LIFE



"One poster can be worth a thousand words," is one way of describing the American Medical Association health information posters which are now available in a two-part series. The 1964 series (A) was so successful, that a second (B) is now being offered for 1965. The posters are vivid, colorful, "one-a-month" reminders of good health practices and are available in the two sets of 12 posters each. Included as part of each poster set is an attractive aluminum frame measuring 19½" x 24". It is suitable for either hanging or standing display. Within the frame is space to store unused posters. There is also space at the bottom for

a name tag that identifies the sponsor of the poster project. Cost of one complete set including the frame is \$8.95 postpaid. The posters may also be ordered without the frame at a cost of \$4.50.

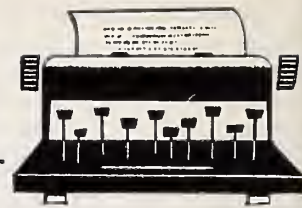
#### Health Pamphlets Will Interest

The new AMA Pamphlet Rack is a handsome metal rack specially designed to help the doctor display and distribute AMA health education pamphlets. The rack has a natural wood grain finish that will add to the decor wherever placed. It measures 19¾" x 5" x 9¾", and can be set on a table or counter, or hung on the wall.

Interested persons may choose from a variety of pamphlets ranging from Safety and First Aid and a Sex Education Series to Child Care and Fitness. The rack and 25 each of any eight pamphlets is only \$8.95 postpaid.

For further information write to the Publication Circulation Section of the AMA, 535 North Dearborn St., Chicago, Ill. 60610; or, both the poster series and the pamphlets and accompanying rack may be ordered from the AMA Order Department at the same address.





## An Urgent Request

**O**N THE YELLOW PAGE in this issue an important questionnaire appears. This questionnaire is pertinent from many points of view. First of all it is important for our readers—because the requirements of our readers should be reflected in the type of state medical journal that is offered to him, and the questionnaire gives us a chance to know what he likes and needs in a scientific publication.

For those of us entrusted with the job of assembling your publication into something which we believe should be worthwhile, this poll of our readers will be of tremendous value.

Besides these two obvious advantages, our adver-

tisers will also be much reassured by an active response from our readers. This will constitute palpable evidence that their ethical products and services are receiving significant reader exposure. It is only with our advertisers' continued confidence in our effective readership that we may expect to compete in the advertising marketplace.

We have had a prize-winning Journal in the recent past. We believe that we still do. But only with the help and suggestions of our members (and all other interested readers) do we feel that we can continue to move ahead. It is earnestly requested that each of us invest five minutes of thought and a five-cent stamp in the future of our Journal.

## Orthostatic Hypotension

**A** MARKED DROP in systolic arterial blood pressure (or in pulse pressure) when the patients stands is frequently seen today by the medical consultant, and it is most often due to drugs which were prescribed by the referring physician. The symptoms produced are often confusing and mystifying to the doctor, and may be very distressful or even fatal to the patient.

### Physiological Adjustments

In the normal individual, many physiological adjustments occur in rising from the supine to the upright position, triggered by the gravitational drop in blood pressure in the carotid sinus and aortic arch baro-receptors. The heart rate increases, helping to maintain cardiac output, and there is some veno-constriction, which decreases the capacity of the veins and diminishes venous pooling in the abdominal viscera and lower extremities. Finally, the arterioles constrict in the abdomen and extremities, helping to maintain the arterial blood pressure.

In the patient with orthostatic hypotension, these

baro-receptor reflexes do not function properly, and, when he attempts to stand upright, there is an inadequate degree of reflex arteriolar vasoconstriction with a subsequent reduction in venous return. This is associated with an immediate and pronounced fall in arterial blood pressure. These patients complain of such symptoms as weakness, dyspnea, palpitation, chest pain, fatigability, dizziness, ataxia, dim vision, tinnitus, nausea, and fainting.

To diagnose orthostatic hypotension, one simply has the patient stand erect and takes his blood pressure in the upright position. It is often quite surprising to discover that a pressure of 150/100 mm. Hg. in the supine position drops to 70/30 mm. Hg. in the erect position—or that a pressure of 160/120 drops to 150/130, resulting in a feeble and ineffectual pulse pressure.

Familiarity with this syndrome can prevent embarrassment and possibly even malpractice suits for the physician, as well as discomfort, serious and expensive illness, and possibly even death of the patient. This editorial is a plea to doctors to take



blood pressures with patients standing, and to teach nurses and medical attendants to do likewise.

There are a number of well-known causes of postural hypotension, which, nevertheless, often go unrecognized because of our habit of taking blood pressures of supine bed patients and sitting ambulatory patients. For decades it has been known to occur after prolonged convalescence and recumbency, having been called "post-infectious asthenia." It is common after surgical sympathectomy for hypertension and in patients receiving sympatholytic drugs (ganglionic blocking agents such as guanethidine and pentolinium). It also occurs in diseases such as diabetes and syphilis, in which there is damage to the sympathetic nervous system. In such organic or functional disease, the sympathetic nervous system is unable to produce the vasoconstriction necessary to compensate for the effects of gravity.

Vasodilator drugs tend to produce hypotension, and hypovolemia from any cause makes it both occur more rapidly and aggravates its effects. Thus, hypertensive patients receiving both ganglionic blocking agents and thiazide diuretics are particularly susceptible, especially since doctors seldom take blood pressures of erect patients and often forget that the patient's pressure may increase 50 mm. Hg. or more in the physician's office. Although they seldom stand upright, patients receiving subcutaneous fluids often develop hypovolemia with critical hypotension resulting from loss of water by osmosis from the vascular space into the hypertonic solution in the extracellular (subcutaneous) space.

### **The Psychiatric Patient**

Psychiatric patients often display orthostatic hypotension which psychoanalytically-oriented psychiatrists tell us represents in "organ language" their "inability to stand up to the problems of life." This is often aggravated by hyperventilation which produces hypocapnia, reduced cerebral blood flow, and a marked tendency to faint. It is these very patients

who also receive drugs which are especially prone to cause a marked drop in blood pressure.

The most notorious drugs today which produce orthostatic hypotension are the phenothiazines (e.g. thorazine, stelazine), monamine oxidase inhibitors (e.g. monase, marsilid, marplan, nardil), and imipramine anti-depressants (e.g. tofranil, elavil). These are all very effective when well tolerated, but their use can be disastrous if severe hypotension occurs and goes unrecognized. The author has also seen hypotension produced in susceptible individuals by practically every one of the commonly used "tranquilizers."

### **Results from Inadequate Blood Flow**

A marked drop in blood pressure results in inadequate blood flow to vital organs, especially via the cerebral, coronary, and renal arteries. Transient hypotension may cause only ischemic effects, but sustained hypotension results in necrosis—of cortical brain cells, myocardial fibers, renal tubular cells. Thus, cerebral injury may be irreversible, producing personality changes, minor neurological losses, or even hemiplegia, especially if cerebral vascular disease is present. Similarly, myocardial damage may result, still further reducing cardiac output and aggravating the effects of the hypotension; and fatal myocardial infarction may occur if the patient has significant coronary atherosclerosis. Likewise, renal shut-down may occur, and the patient may die, in uremia, of irreversible renal failure, especially if he has significant renal vascular disease.

Such dire consequences can be prevented if the physician will (1) keep this syndrome in mind, (2) avoid such drugs when another drug will have the desired effect, (3) take erect blood pressures on all patients in the above categories, (4) stop offending drugs promptly, (5) warn patients of symptoms of potential side effects, (6) treat the condition promptly and adequately with recumbency, elastic bandages, and vasopressors as required.

## **AMA Clinical Convention Highlights**

*The following is a summary of the activities of the House of Delegates at the American Medical Association's 18th Clinical Convention held November 29-December 2, 1964, in Miami Beach, Florida. It is not intended to be a detailed account of the proceedings, but merely covers the highlights of that meeting.*

THE HOUSE OF DELEGATES met during November and December of 1964 to act on many topics of

current and projected importance to the profession. Among the many subjects taken under consideration by the House included, health care for the aged, a new teletype communications system between the AMA Headquarters and all state medical societies (within the continental United States), and human reproduction.

At the opening session of the House tribute was paid to the late Dr. Norman A. Welch, AMA President who died on September 3. A memorial



statement offered by the Massachusetts Medical Society was adopted.

Dr. James Z. Appel, Lancaster, Pennsylvania, Vice Chairman of the AMA Board of Trustees and a member of the Board since 1957, was named President-Elect of the Association. He will take office at the Annual Convention in June, 1965.

### Health Care for the Aged

Definitive action on the issue of health care for the aged came with the House of Delegate's strong endorsement of AMA President Donovan F. Ward's address, in which he declared that, "We have no choice except to stand firm in our efforts to prevent the standards of health care in this country from being undermined by a radical departure from the unique American way which has accomplished so much for mankind."

Reaffirming the AMA's opposition to King-Anderson type legislation Dr. Ward said;

"If we were right in the past—and that is our unshakeable belief—then we are right today. And we shall be right tomorrow."

Calling for renewed effort against such legislation, he pointed out that, "we do not, by profession, compromise in matters of life and death. Nor can we compromise with honor and duty."

"I pray that we all gain strength for renewed effort by the simple reflection that what we are doing is worthwhile—that if the effort is great, the results of not making the effort would be unthinkable—and finally, what we are doing is vastly more important than ourselves."

To implement the ideas in Dr. Ward's address, the House gave unequivocal approval of a Board of Trustees suggestion that an expanded educational program be conducted in the next few months.

### Teletype Communications System

The House approved a recommendation from the Board of Trustees for establishment of a teletype communications system between the AMA and the state medical societies. The system will provide automatic and uninterrupted communications between the AMA Headquarters and all participating state societies, and between the state societies without involving the facilities at the AMA. Participation in the system is optional on the part of state societies.

Installation and rental cost for the teletype equipment, both at AMA and at the headquarters of each participating state society, will be paid by the AMA. The only cost to be incurred by the state societies will be that involved when they originate messages. It is hoped the system will become operational no later than July, 1965.

### Human Reproduction

Updating its policies on population control, the House adopted the following four-point statement:

"(1) An intelligent recognition of the problems that relate to human reproduction, including the need for population control, is more than a matter of responsible parenthood; it is a matter of responsible medical practice.

"(2) The medical profession should accept a major responsibility in matters related to human reproduction as they affect the total population and the individual family.

"(3) In discharging this responsibility, physicians must be prepared to provide counsel and guidance when the needs of their patients require it or refer the patients to appropriate persons.

"(4) The AMA shall take the responsibility for disseminating information to physicians on all phases of human reproduction, including sexual behavior, by whatever means are appropriate."

The House also recommended that the AMA cooperate with appropriate voluntary organizations in the field of human reproduction which have adequate medical direction.

### Miscellaneous Actions

In considering a wide variety of annual, special and supplemental reports and resolutions, the House took the following actions:

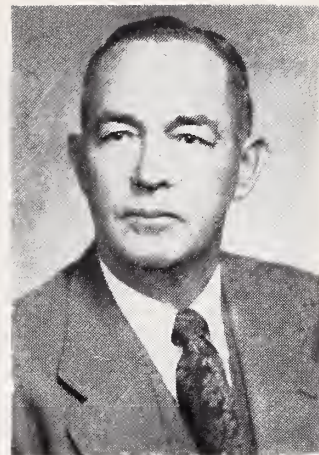
Urged strong support of the Woman's Auxiliary and asked the state and county medical societies to give serious consideration to the idea of joint husband-wife memberships;

Emphasized its continuing awareness of the demand for action on satisfying the need for increasing numbers of family physicians;

Urged all state and component medical associations to approve, where feasible, the inclusion of a voluntary, nondeductible contribution to independent political action committees on the societies annual dues billing statement.

# PRESIDENT'S LETTER

---



## OUR JOURNAL

**F**OR MANY YEARS NOW, I have meticulously gone over the contents of our *Journal of the Medical Association of Georgia*. I have done this because ever since becoming a Vice Councilor—a good many years ago—I felt that it was part of my responsibility to be sure that the doctors in Georgia received as much for their money or more than any other state in the union.

Our Journal has pleased me through these years. I can take no credit for it; I wish I could—but, on second thought, maybe I can—certainly it has never occurred to the Executive Committee or the Council to change Editors, nor has it occurred to us to challenge his help in the office. He makes recommendations, and we go along with them. Because of this and this only, can we reflect a little in its excellence.

Some years ago Dr. Edgar Woody, our Editor, received two awards for the Journal, for excellence; one from the State Medical Journal Advertising Bureau and one from the American Medical Writers Association. We must remember that Dr. Woody is a practicing physician, the same as most of us. As Editor, he has to select the scientific papers that go into the Journal. They have to be edited. Only a certain number can go in each month, and then there must be editorials on current subjects; news events; advertising; personal notes; and all those many, many things that make something worthwhile, but that can get fouled up so easily. The Journal you see each month is the result of a great deal of hard work by him and his staff. Once something is in print, it's in print and can't be erased.

There is no way that he can get around over Georgia and ask you who own this publication, just exactly what you think of it. This worries him a little bit. By other standards he has a splendid state medical journal, but he wonders if it couldn't be still better, since comparison to other state medical journals might not be the answer in Georgia.

He has arrived at a way, that if we will just take a few minutes to cooperate, may make a great deal of difference in your MAG Journal in the future.

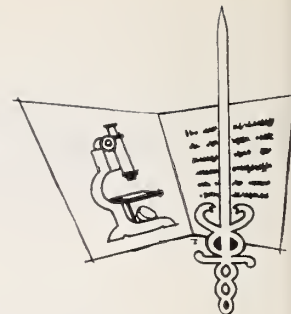
The Yellow Page questionnaire in this issue is simple to fill out, will take only a few minutes, and will be of inestimable value. If you do not want to fill it out in its entirety, fill out a part. But please send it in.

*It's your Journal!*

A handwritten signature in dark ink, reading "J. G. McDaniel".

J. G. McDaniel, M.D.  
President, Medical Association of Georgia





## CHONDROSARCOMA OF BONE

Perry M. White, M.D., *Atlanta*

**C**HONDROSARCOMA is a malignant tumor arising from cartilage cells and in its course tends to remain cartilaginous in appearance. As any other tumor, chondrosarcoma may be or become so undifferentiated as to make its diagnosis difficult at times.

### A Definite Entity

Unlike chondrosarcoma, osteosarcoma arises from a more primitive connective tissue cell. Any cartilage the osteosarcoma forms is by differentiation from the basic sarcomatous spindle cell connective tissue while the same cell is forming tumor osteoid and osseous tissue. The two most common primary bone tumors differ in the clinical course in that the chondrosarcoma usually has a slower rate of growth. Even more important, the chondrosarcoma has a more favorable prognosis. There seems to be no doubt that the chondrosarcoma is a definite entity to be distinguished from the osteosarcoma.

For the purpose of this page, chondrosarcoma may be classified as central and peripheral, the central type being that of primary interest here. Central chondrosarcoma refers to that lesion developing within bone either primarily or from a pre-existing benign cartilage lesion (secondary). However, the basic pathological and clinical features hold true for the peripheral types developing outside of the bone.

The incidence of chondrosarcoma is about one-half that of osteosarcoma. Therefore, it is not very commonly encountered. About ten per cent of malignant bone lesions are chondrosarcomas. Whereas osteosarcomas are thought of as a young person's tumor, chondrosarcomas are thought of as occurring in the middle aged group with a median age of 45 years. The range is great, though, with few below 30 years and more than half above 40 years. As to sex distribution, the balance seems to fall in favor of the male showing the greatest incidence, but not greatly so.

Those patients presenting with chondrosarcomas most often complain of pain locally. The pain is usually a dull, aching pain, intermittent and early, but becoming more constant as the lesion continues

to expand. Usually such complaints have been present for some months, but it is not unusual to obtain histories of one to three years' duration. If the lesion involves the end of a long bone, joint symptoms of stiffness, effusion and weight-bearing pain may be present. Sometimes local swelling may be present, especially if the cortex has been violated, and sometimes by simple expansion of the bone. The mass is most often very firm and slightly tender but does not demonstrate the usual signs of infection or inflammation. A short history of pain followed by occurrence of a mass indicates a highly malignant cartilage tumor with a poor prognosis.

The roentgenogram then follows the above thoughts and frequently, though not always, lends much help in diagnosis and planning of therapy. Fortunately the central chondrosarcoma frequently has spotty calcification scattered about the radiolucent area, helping to direct ones thoughts to a cartilage lesion. In the minority are those tumors represented by radiolucency and no other distinguishing characteristics except a bulging thin cortex with a tendency to loculation.

### Calcification

As noted earlier, the majority of the central chondrosarcomas present spotty radiopacity which indicates calcification of the tumor matrix. Chondrosarcoma is a slow growing tumor, and as a rule, one doesn't find eruption through the cortex, but instead, an uneven cortex thinned in places and thickened in other places. In other areas, the cortex may be actively invaded and thusly will appear moth eaten or fuzzy. When the tumor does break through the cortex, the extraosseous tumor usually rapidly assumes spotty calcific changes and makes one more certain of the character of the lesion. Benign cartilage tumors usually have a rather definite border and rather heavy central calcification, but should malignant changes occur, the definite margin becomes spotty and fuzzy. To a lesser degree, the central radiopaque spots lose their specificity due to destruction by activated tumor cartilage cells.



To the pathologist, cartilage tumors more often than not pose a great challenge. The surgeon who biopsies a suspected tumor should attempt to provide the pathologist with a generous specimen, trying to include active portions of the tumor from its periphery. For accurate diagnosis, many fields frequently have to be studied and then fitted in with the clinical picture. Grossly, the chondrosarcoma is a lobulated grayish-white to bluish color most often with a gritty texture due to calcification. Of course, hemorrhagic spots may be seen and even areas degenerated into a soft gelatinous mass. The greatest problem is the histologic interpretation, but if a solitary lesion demonstrates more than an occasional cell with a large double nuclei, and noticeable increase in cellularity and plumpness of the nuclei, suspicion of a malignant process should be aroused. Such would not necessarily be true for a biopsy from someone with multiple cartilage lesions, however. In any lesion with marked changes in size and shape of nuclei, numerous multinuclear cells and pronounced hyperchromatism of the nuclei should be regarded as a chondrosarcoma.

The differential diagnosis of chondrosarcoma involves solitary and multiple enchondromas which usually have an oval shape with rather well-limited margins of compacted bone trabeculae and slight bulging or thinning of the cortex except in the small bones of the hands or feet. The chondromyxoid fibroma may give cause for alarm due to its confusing histologic pattern, but the clinical behavior is unlike a chondrosarcoma. Recurrence is unlikely after curettage of a chondromyxoid fibroma, but is probable in the case of a chondrosarcoma.

The most important differentiation is the osteosarcoma seen in younger people. The clinical history of osteosarcoma is more rapid, the gross appearance of the tumor does not present a cartilage-like appearance, and most often no difficulty is encountered in the microscopic characteristics.

### **Surgical Treatment**

Treatment of chondrosarcoma is surgical but should be preceded by adequate biopsy. If frozen section technique is not dependable in a given situation, it is safe to await preparation of a paraffin section. It must be remembered that the biopsy lesion might be seeded with tumor cells and should be placed below planned definitive surgery, should such be required. Local resection of a small tumor with little if any cortical involvement might be considered if reconstructive means are at hand. In those larger tumors and in those that have broken through the cortex, ablation above the next proximal joint is indicated. In those areas with poor access, resection locally as radically as possible has to suffice. Irradiation serves as a temporary palliative agent against pain and should not be expected to offer any more.

In conclusion, a bone lesion of mixed radiolucency-radiopacity producing increasing pain in the fourth through seventh decade should be suspected of being a chondrosarcoma of bone and proper diagnostic steps should be taken. With earlier diagnosis and more adequate surgery, the survival rate of patients with chondrosarcoma is increasing.

*340 Boulevard, N.E.*

*Approved by the Professional Education Committee, Georgia Division, ACS.*

## **AMERICAN COLLEGE OF SURGEONS SECTIONAL MEETING TO BE HELD IN ATLANTA IN JANUARY**

The American College of Surgeons will hold the first of three 1965 Sectional Meetings in Atlanta, January 25-27, 1965. More than 500 surgeons are expected to attend this scientific three-day program, open to all doctors of medicine. Headquarters hotel will be the Atlanta-Biltmore.

Sectional Meetings are short, concentrated programs designed to inform the medical profession at large about developments in surgery. Surgeons of outstanding ability serve as teachers, focusing attention on newer ways of handling problems encountered in day-to-day practice. Panels, symposia, papers, and films of value are presented.

More than 50 participants are listed on the program, which will include sessions in the specialties of thoracic and plastic surgery as well as in general surgery. Among topics of discussion: treatment of tetanus, gastrointestinal bleeding of obscure etiology, chemotherapy of cancer, left lower quadrant abdominal mass, pelvic in-

flammatory disease, principles of organ transplantation, septic shock, thermal burns, repair of cleft palate complications, surgery of arthritic hand, synthetic materials in plastic surgery, pacemakers — types, indications and techniques of insertion, thoracic and thoracoabdominal injuries.

Dr. Duncan Shepard, Atlanta, is chairman of the local program planning committee, assisted by William H. Bennett, Edgar Boling, F. Phinzy Calhoun, Jr., Ernest B. Dunlap, Jr., Charles E. Holloway, Richard King, John D. Martin, Jr., W. Vernon Skiles, Jr., Robert H. Stephenson, Homer S. Swanson, James C. Thoroughman, John P. Wilson, Edward S. Wright, Charles P. Yarn, Jr., and Asa G. Yancey.

Other 1965 Sectional Meetings are: Philadelphia, February 15-17; and Seattle, March 8-11, the annual four-day joint meeting for doctors and nurses.

Official hotel housing forms may be obtained from: Mr. T. E. McGinnis, American College of Surgeons, 55 East Erie Street, Chicago 60611.



## CATHETERIZATION IN CONGENITAL HEART DISEASE IN THE VERY YOUNG AND IN THE MIDDLE YEARS

Robert H. Franch, M.D., *Atlanta*

**T**HE CARDIOVASCULAR laboratory flourishes best in an environment of good general medicine, pediatrics and surgery. One cannot expect an outstanding cardiac unit in an otherwise poor hospital. Its most important ingredient is a thoroughly experienced technical-professional team that includes a radiologist, skilled and interested in angiographic techniques. There should be sufficient case load to maintain a reasonably continuous experience for the group. The object of the laboratory should be to complete an accurate cardiac diagnosis in one sitting with the least possible risk and discomfort to the patient.

### Delay in Diagnostic Tests

In congenital heart disease, a tendency to delay diagnostic tests may occur in patients falling into two age groups; first, the tiny infant and second, the adult over 30 years of age. Of 4.3 million live births in the U.S.A., 25,000 newborns had congenital heart disease, and of these, 6,370 were dead by one month of age. It is estimated that one-half of these were potentially salvageable. Two-fifths of cases developing heart failure in the first week of life have aortic atresia and are not treatable. Since approximately one-half the mortality from congenital heart disease occurs in the first year of life from heart failure or hypoxia, it is clear that an aggressive diagnostic and surgical approach is needed early to avoid the bulk of deaths in this age period.

Thus, congenital heart disease should not be overlooked in the nursery. The neonate, without murmurs, whose chest X-rays show lung fields that look like a snow storm, may have total anomalous pulmonary venous drainage with severe pulmonary hypertension due to pulmonary venous obstruction. This physiological state can be helped by surgery. Coarctation of the aorta should be suspected in every infant with heart disease, especially if heart failure occurs from one to four weeks of age. Respiratory difficulties may not be primarily pulmonary but may be due to left ventricular failure.

In the tiny infant, physical signs may be less clear; on X-ray a large thymus may interfere with the evaluation of cardiac and great vessel contours (except in transposition of the great vessels where the thymus shadow is usually absent). If, after careful clinical evaluation, the cardiac diagnosis is still uncertain, and if the infant's condition calls for a precise answer, special studies can and should be done with reasonable safety and ease. The seriousness of the cardiac abnormality is not a contraindication to selective angiocardiology. The counter-current injection of contrast media into the left brachial artery readily defines coarctation of the aorta, patent ductus arteriosus, or aortic hypoplasia or atresia. These procedures require no anesthesia. Though the incidence of congenital heart disease is low and the cost of treatment high, the direct economic gain per patient is large, since early surgical correction permits long-term survival and a productive life.

### May Be Overlooked

In adults, congenital heart disease may be overlooked because of the preponderance of acquired heart lesions and the unavoidable prejudice predisposed to by this difference in frequency. Thus atrial septal defect is frequently diagnosed as rheumatic mitral stenosis or mitral insufficiency. The patient with patent ductus may survive to old age and patients with moderate valvular pulmonic stenosis are not uncommon in the fifties; lack of cardiac symptoms until middle age does not exclude congenital heart disease. Cyanotic congenital heart disease is rare after 40 years of age, except for Ebstein's Disease. Congenital heart disease should be included in the differential diagnosis of all adults with known or suspected heart disease and physiological studies should be used when necessary to clarify the diagnosis.

401 Woodruff Building  
Emory University School of Medicine

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.





## WITHDRAWAL OF CONSENT

John L. Moore, Jr., *Atlanta*

EVERY PHYSICIAN knows that the relationship of physician and patient is a consensual one. Therefore, a physician who undertakes to treat a patient without express or implied consent of the patient is guilty of at least a technical battery.

Under what condition may a patient who has employed a doctor and therefore consents to his treatment withdraw that consent?

That important question has been the subject of a recent ruling by the Court of Appeals of Georgia.

### Facts of Case

The plaintiff, a lady, had been a patient of the physician for eight years. The physician had performed surgery on the plaintiff for cancer, removing her rectum, most of her large colon, and a third of her bladder and creating a colostomy through her abdominal wall.

During the eight year period the physician did regular examinations in order that any possible recurrence of cancer might be promptly detected and prevented.

During most of the examinations, the patient had been given barium by mouth in connection with X-raying the intestinal tract. However, the physician decided a barium enema would be more effective. The patient objected to the enema which was administered by technicians in the office of the physician and complained about the pain she suffered while it was being administered.

The patient then sued the physician and the technicians involved, alleging an unauthorized battery upon her resulting in damage to her colon and pain and suffering. After hearing all of the evidence, the jury returned with a verdict in favor of the physician.

### Court's Holding

On appeal, the Court of Appeals affirmed the decision for the physician. In doing so, the Court of Appeals wrote a very careful opinion setting out the legal rules as to consent to treatment and withdrawal of it. The Court stated the basic rule that the relation of physician and patient is a consensual

one, and a physician who undertakes to treat another without express or implied consent of the patient is guilty of at least a technical battery. Any unauthorized and unprivileged contact by a doctor to his patient in examination, treatment, or surgery would amount to a battery. However, the doctor can do no actionable wrong to the patient if the patient consents to the procedure and the physician, of course, is not negligent in performing the procedure.

Consent to medical or surgical treatment may be manifest by acts and conduct and need not necessarily be shown by writing or by express words. Consent may be inferred from voluntary submission to examination, treatment, or surgery with full knowledge of what is going on.

In the case reported, the patient claimed that her consent to examination did not extend to and include the enema when she discovered that the barium was to be administered by enema and not orally. The Court held that this was not a sufficient allegation of withdrawal of consent. However, it went on to state the general rule applying to consent and its withdrawal by a patient.

Even after treatment or examination is underway, consent can be withdrawn so as to subject a doctor to suit for assault and battery if he continues the contact with the patient, provided, however, the physician's withdrawal under the medical circumstances then existing would not endanger the life or health of the patient. In order for the patient to prove an effective withdrawal of consent as a matter of law after treatment or examination is in progress, the Court of Appeals of Georgia held that two distinct things are required:

- "(1) The patient must act or use language which can be subject to no other inference and which must be unquestioned responses from a clear and rational mind. These actions and utterances of the patient must be such as to leave no room for doubt in the minds of reasonable men that in view of all the circumstances consent was actually withdrawn;

"(2) When medical treatments or examinations occurring with the patient's consent are proceeding in a manner requiring bodily contact by the physician with the patient and consent to the contact is revoked, it must be medically feasible for the doctor to desist in the treatment or examination at that point without the cessation being detrimental to the patient's health or life from a medical viewpoint."

The burden of proving each of these essential conditions is on the plaintiff who sues the physician. Further, the second point as to the medical feasibility of desisting in the treatment or examination can only be proved by expert medical testimony.

The well-written decision of the Court of Appeals of Georgia shows a complete understanding by the Court of the relation between physician and patient. The Court, in essence, simply says that if a difficult situation arises with a patient resisting treatment or examination, the physician should apply his expert medical judgment to the question of whether to desist or proceed.

Should a patient resist treatment or examination, the physician must immediately analyze the situation as follows:

1. Does the patient understand what is going on and what he is saying?
2. Is the patient trying to withdraw consent to treatment or examination?
3. Can there be an adverse medical effect on the patient's condition if the procedure involved is discontinued at the request of the patient?

If the withdrawal of consent arises in a routine physical examination where the patient's immediate health is not an issue, it is obvious that a physician who refuses to cease a particular procedure may well be subject to suit for assault and battery. If, on the other hand, cessation of the procedure could adversely affect the life or health of the patient in the medical judgment of the treating physician, he should continue with the procedure.

*Suite 1220, C&S Bank Building*

*Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.*

## ARTHRITIC SEMINAR TO BE PRESENTED IN ATLANTA IN FEBRUARY

A Seminar on Arthritis will be held at the Academy of Medicine in Atlanta on February 13-14, 1965, under sponsorship of the Georgia Chapter of the Arthritis Foundation. The announcement was made by Dr. Vernon E. Powell, President of the Georgia Chapter.

The distinguished faculty for the seminar will include Doctors Howard F. Polley, Mayo Clinic; Lee

Ramsay Staub, Hospital for Special Surgery, New York City; Charley J. Smyth, Medical Center, University of Colorado; Mack L. Clayton, Denver Orthopedic Clinic; Robert L. Bennett, Warm Springs Foundation; William S. Clark, President, The Arthritis Foundation; and Ronald Lamont-Havers, National Institute of Health, Bethesda, Md.

## NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Name</i>	<i>Address</i>
Coffsky, Jay S. DE 2 — Richmond	Eugene Talmadge Hospital Augusta, Georgia	Logan, H. Edward Active — Richmond	325 Georgia Avenue N. Augusta, S. C.
Eason, Harmer O., Jr. Active — Dougherty	108 N. Monroe Street Albany, Georgia	McLaren, John R. Active — DeKalb	Emory University Clinic Atlanta, Georgia 30322
Edmonds, John H., Jr. Active — Richmond	Medical College of Georgia Augusta, Georgia	Moore, Mel T. Active — DeKalb	3646 Market Street Clarkston, Georgia
Elson, Shia H. Active — Fulton	478 Peachtree Street, N.E. Atlanta, Georgia 30308	Ogden, Lynn, L., II Active — Richmond	Medical College of Georgia Augusta, Georgia
Greenberg, Wayne V. Active — Richmond	1459 Gwinnett Street Augusta, Georgia	Perkins, Jack B. Active — Fulton	Emory University, Dept. of Anes. Atlanta, Georgia
Jackson, Caesar Edward DE 2 — Richmond	Eugene Talmadge Hospital Augusta, Georgia	Sherman, Harry C. Active — Richmond	1538 Gwinnett Street Augusta, Georgia
Kattine, Anthony A. Active — Fulton	Emory University, Dept. of Path. Atlanta, Georgia	Yeh, Jui-Ting Thomas Active — Richmond	Eugene Talmadge Hospital Augusta, Georgia





## A COMMUNITY SCHOOL FOR THE TRAINABLE RETARDED CHILD

Harvey Newman, M.D., *Gainesville*

THESE THINGS are so . . . .

Community responsibility in its purist definition is a retarded child. Local effort has become a symbol of hope and encouragement. Communities are experiencing a new sense of personal satisfaction as a result of their own effort.

### Facilities Available

Many localities have facilities for the educable retarded child in conjunction with federal and state funds. It has been found practical to work with the trainable child, if the child is not in the class of custodial care in its strictest application. Frequently there is potential for further development of certain skills in the areas of self-help, socialization and oral communication. Educators, in their evaluation of programs for the trainable retardee are finding that a normal nursery school program is the best method. Progress is geared to the ability of the individual child. The retardee is encouraged and challenged to develop to the fullest those talents with which he is blest.

It is reasonable to believe this community problem can be alleviated to a great extent without a large number of trained and specialized personnel.

In a community there was first formed a local organization composed of parents and friends of retarded children. The organization first noted the presence of classes for the educable child in the city and county school systems. Then its interest became principally directed toward the trainable child. The trainable child, it found, was not provided for in any community service.

At first, a committee met with a kindergarten faculty. It decided to use the current, creative-type program from the normal play school and kindergarten. A local church-sponsored kindergarten building was donated for afternoons when it was not in use. The church readily encouraged the development of the trainable child program as a part of its Christian ministry to the community. The kindergarten faculty was employed, along with a maid and volunteer helpers to conduct the program. The teacher-director of the normal kindergarten merely increased her daily schedule of work and planning.

Friends of the retarded child, principally civic clubs such as Kiwanis, Civitan, United Commercial Travelers, and Junior Service League rapidly came

forth with financial aid. Soon, with minimal newspaper publicity and much word-of-mouth treatment, the contributions poured in. From a beginning in early Summer to the opening of the school in the Fall, parents were contacted. Psychological evaluations of their children were made to classify them as to ability and potential. At this beginning, both the retardee and the brain damaged were accepted without great differentiation. Any child who could get transportation to the school was accepted on a trial basis subject to the condition that he could adjust happily to the group situation.

A tuition schedule was proposed, based on normal kindergarten rates, but was easily altered so that all eligible might attend regardless of their financial condition.

Of course, due to the ratio of students to teacher, the tuition income did not contribute significantly to the operation of the school.

The school started in the fall, in the afternoon, following the regular kindergarten classes. Children were taken to the room by their parents. Information on the child had been obtained from the parent, psychologist and physician. This information was on file readily at hand for reference and largely committed to memory by the personnel.

The first year was a great success. At the end of the year a meeting with the parents was held and evaluation of the child's progress and its effect on the family was estimated. The response was one of delight to the staff and sponsors. Parents and friends are now oriented as to what they can do at home and in the community. The constant and often unsuccessful search for help at state and federal level for custodial care is being reduced. There is a sense of confidence and mutual progress among the parents. The children have learned to engage in cooperative play and have found a world in which they can compete without dismal and repetitive failure.

The retarded child has been helped, the parents are optimistic again, the church is expanding its place in community service as a Christian ministry, and the community has the satisfaction of meeting a challenge and salvaging a problem situation.

*1116 South Enota Drive, N.E.*

*Prepared at the request of the Sub-Committee on Mental Health of the Medical Association of Georgia.*



## DEATHS

**JAMES M. BURDINE**, 44, Atlanta physician, died November 4, 1964, in a private hospital.

A native of Marble Hill, Georgia, he attended Union College in Kentucky and later the Medical College of Georgia where he received his doctor of medicine degree.

An honor graduate, Dr. Burdine was a well-known athlete during his high school and college career.

He served in both World War II and the Korean Conflict as a doctor in the medical corps. During the Korean Conflict, he was a major and a flight surgeon in the Air Force.

He had practiced in Blue Ridge for five years and was city physician there before the Korean War. He later practiced at Ellijay for four years before coming to Atlanta.

He began a practice here in 1956.

He was a member of the Fulton County, Georgia and American Medical Associations, the Theta Kappa Psi Fraternity and Ansley Park Golf Club.

Surviving are his wife; a son, James M. Burdine, Jr., and a daughter, Patricia Burdine and two brothers, Dr. Winston E. Burdine and Essley Burdine.

Waycross physician, **ARTHUR WILLIAM DeLOACH**, died October 24, 1964.

Dr. DeLoach is survived by his wife, the former Sarah Polkinghorne of Waycross, and two sisters, Mrs. M. C. Grayson of Clover, S. C. and Mrs. C. H. Kreps of Columbia, S. C.

**CLARENCE W. MILLS, JR.**, Atlanta internist, died November 16, 1964, in a local hospital.

An Atlanta native, Dr. Mills, 45, attended Emory University and the Emory Medical College. He was a member of the Cherokee Country Club and a former elder of the Peachtree Road Presbyterian Church.

Surviving are his widow, the former Betty Sutherland; a daughter, Sally Mills; sons Chriss, Patrick and Kelly Mills and his parents, Mr. and Mrs. C. W. Mills, Sr., all of Atlanta.

**JOHN EARNEST POWELL, SR.**, Villa Rica, died at his home September 8, 1964, after an illness of six weeks. Seventy-two years old, he graduated from Emory University College in 1915 with the second highest honor in the class. He had practiced in Villa Rica for 49 years, and was a member of the Carroll-Douglas-Haralson County Medical Society, the Medical Association of Georgia, and the AMA. Active in civic organizations, he was a member of the Masonic Shrine, the Civitan and Kiwanis Clubs, and a member of Alpha Kappa Gamma fraternity. He served for many years as a Trustee of the Villa Rica Methodist Church and was a Steward at the time of his death.

**DONALD W. SINGLETON**, Atlanta surgeon, died November 14, 1964, at Brunswick. He was 42 years old.

Dr. Singleton practiced in Atlanta for 12 years following an internship at the Methodist Hospital in Memphis, Tennessee. He graduated from the University of Tennessee Medical School and was a surgical resident at the Georgia Baptist Hospital in Atlanta.

He was a member of the Fulton County and American Medical Societies, a Mason, Shriner and a member of the American College of Surgeons.

He was on the Board of Stewards at Peachtree Methodist Church.

Surviving are his wife; two daughters, Miss Betty Knox Singleton and Miss Nancy Bailey Singleton, one son, Donald Ware Singleton, Jr., all of Atlanta, his mother, Mrs. W. A. Singleton of Myrtle Beach, S. C., three sisters, Mrs. Paul MacMeekin and Mrs. Chesley Wise, both of Myrtle Beach, and Mrs. Hilton Fuller of Atlanta, and five brothers, Byron Singleton of Atlanta, Frank Singleton of Myrtle Beach, J. Knox Singleton of Springfield, Virginia, Burt N. Singleton of Florence, South Carolina and W. A. Singleton of Murphy, North Carolina.

## SOCIETIES

George Conner, M.D., was installed as President of the MUSCOGEE COUNTY MEDICAL SOCIETY for 1965 at the group's annual meeting November 24 in Columbus. Installed as President-elect for 1966 was Louis A. Harzouri, M.D. Roy L. Gibson, M.D., was elected to the Board of Censors; Luther H. Wolff was re-elected councilor, and Dr. Gibson was re-elected Vice Councilor.

At the regular meeting of the WALKER-CATOOSA-DADE County Medical Society on November 24, a new slate of officers was selected for 1965. New officers will be installed at the regular monthly meeting on January 26, 1965.

Those elected were:

President—John C. Ellis, M.D., Rossville

President Elect—Murphy K. Cureton, M.D., LaFayette

Secretary-Treasurer—Gordon L. Hixson, M.D., Fort Oglethorpe.

Delegate, 1965-66—John P. Hoover, M.D., Rossville

Alternate Delegate—Fred H. Simonton, M.D., Chickamauga

Board of Censors 1965-67—Howard C. Derrick, M.D., LaFayette

## PERSONALS

Three Georgians were among 313 pediatricians elected to fellowship in the American Academy of Pediatrics at its recent meeting in New York. Named were THOMAS L. TIDMORE, Atlanta; EDGAR A. VAUGHN, Marietta; and WILLIAM W. AUSBON, Columbus.



### First District

FRANKLIN BOUSQUET, JR., Savannah, was elected Chairman of the Candler Hospital Eye, Ear, Nose and Throat Department at its organizational meeting in November. Other officers include JOHN HOWARD, Vice Chairman, and J. LANE REEVES, Secretary.

Dr. M. FERNAN-NUNEZ of Savannah addressed the house medical staff of the Memorial Hospital of Chatham County, at its regular meeting, November 6. His topic was "The Pathology of African Tropical Diseases," and was illustrated with colored motion pictures taken by him as a member of the Royal Spanish Sleeping Sickness (Trypanosomiasis) Expedition to Spanish Equatorial West Africa (Rio Muni). Dr. Fernan-Nunez is Senior Pathologist of the Howard Clinical Laboratory, Savannah, and Consulting Pathologist to the Memorial Hospital.

### Third District

BILL BRIDGES, who has been engaged in the general practice of medicine in Dawson for the past five years terminated his practice December 1 to enter the study of radiology at Grady Memorial Hospital, Atlanta.

FRANK WILSON, III, Leslie, presented a program in November to the Auxiliary to the Sumter County Medical Society. His subject, "Pulse of Life," dealt with mouth to mouth resuscitation and heart message.

### Fifth District

LEONARD L. COTTS and Mrs. Cotts, Atlanta, have announced the birth of twin daughters November 18, 1964.

DIXON A. LACKEY, JR., Atlanta pediatrician, has recently been appointed Director of the Crippled Children's Service of the Georgia Department of Public Health.

JOHN E. STEINHAUS, Emory University School of Medicine, presented a paper entitled, "Central Nervous System Effects of Local Anesthetics," at the Third World Congress of Anesthesiologists in Sao Paulo, Brazil, September 20-26. He was a delegate to the American Society of Anesthesiologists meeting in Miami, October 10-14.

Attending the 29th meeting of the American College of Gastroenterology held in New York City, October 19-22, was G. C. BARRETT, Atlanta. He presented a three-part exhibit on "Cinefluorography of Lesions of the Upper Gastro-Intestinal Tract." The exhibit was awarded first prize.

Four faculty members with 171 years of service to Emory's department of Gynecology and Obstetrics have received the Department's first "Outstanding Clinical Professor Awards."

The four are RUDOLPH A. BARTHOLOMEW, EMMETT D. COLVIN, WALTER R. HOLMES and CHARLES B. UPSHAW, SR.

SIDNEY OLANSKY, MARY LOU APPLEWHITE, and MARIAN OLANSKY attended the meeting of the Southern Medical Association recently. Dr. Applewhite and Dr. Sidney Olansky, who is Secretary of the Dermatology Section, participated in the Dermatology Section Meeting. In addition, Dr. Sidney Olansky was

moderator and participant in a symposium on venereal diseases on Wednesday morning, November 18, 1964.

This meeting was held in Memphis, Tennessee.

LESTER M. PETRIE, Atlanta, has recently received the Prize Award of Merit for 1964 for meritorious service to the people of the United States and the medical-health professions for his endeavor in the interest of civil defense. Dr. Petrie, since 1950, has been deputy director of civil defense health services for Georgia. The award was presented at the annual conference of the United States Civil Defense Council held November 1-6, at Colorado Springs, Colorado.

CHARLES FULGHUM and A. C. RICHARDSON, Atlanta, served on the planning committee for an October seminar on the Family in Health and Illness sponsored by the Department of Christian Education of the Episcopal Diocese of Atlanta and the Committee on Medicine and Religion of the Fulton County Medical Society. The symposium, held at All Saint's Episcopal Church, Atlanta, included guest speakers from Philadelphia, North Carolina and Washington, D.C.

Recently elected as the new President of the Southern Psychiatric Association was JOSEPH S. SKOBBA, Atlanta. The meeting was held October 2-4 at Kansas City, Missouri.

L. A. WALKER, R. D. GERLE, J. L. ACHORD and H. S. WEENS, Atlanta, spoke to the annual meeting of the Radiological Society of North America, November 29-December 4 in Chicago. The topic was "Osseous Changes in Chronic Pancreatitis."

At its annual meeting at the Johann Wolfgang Goethe University, Frankfurt/Main, Germany, September 10, 1964, the Executive Committee of the International Council on Alcohol and Alcoholism elected VERNELLE FOX, Atlanta Medical Director, Georgian Clinic, to a four-year term on the Council.

BRUCE LOGUE recently addressed a meeting of the Georgia Association of Nurse Anesthetists. The title of his talk was "Preoperative Evaluation and The Management of the Cardiac During Surgery and the Post-operative Period."

MARTON MAJOROS and JOHN A. TUCKER of the Ponce de Leon Infirmary, Atlanta, were elected Fellows of the Academy of Ophthalmology and Otolaryngology at the October meeting of the Academy.

HELEN W. BELLHOUSE, Atlanta, presented a paper entitled "Utilization of Postneonatal Death Certificates Matched With Birth Certificates in a Study of Needs," at the 92nd Annual Meeting of the American Public Health Association in New York in October. Dr. Bellhouse was also 1964 Chairman of the Maternal and Child Health Section of the American Public Health Association and presided at two section sponsored sessions.

Emory University faculty members taking part in a three-day November seminar concerning the close relationship of systemic illness and disturbances of nervous system function were RALPH HEINZ, ROBERT F. KIBLER, WILLIAM MARINE, STEVEN B. MAYER, ALEXANDER M. McPHEDRAN and WILLIAM C. WATERS, III. HERBERT R. KARP was the Director.

### Sixth District

Four Macon doctors have opened the New Street Professional Building at 675 New Street. WILLIAM K. JORDAN and EDMUND BRANNEN will specialize in obstetrics and gynecology, A. M. PHILLIPS, JR. in orthopedics, and ROBERT H. JONES in internal medicine and gastroenterology.

WILLIAM A. DODD, Wrightsville, attended a comprehensive postgraduate course on fractures and other injuries sponsored by the committee on injuries of the American Academy of Orthopaedic Surgeons recently.

### Tenth District

WILLIAM WHATLEY BATTEY, Augusta, received papal honors at a ceremony November 29 at St. Mary's-on-the-Hill Catholic Church. Dr. Battey was formally

invested as Knight of Saint Gregory the Great by Bishop Thomas J. McDonough. The honor was conferred earlier this year by Pope Paul VI.

The order, instituted by Pope Gregory XVI in 1831, is among the best known of all Pontifical orders of Knighthood.

Only those persons who show distinguished loyalty to the Holy See or who exhibit the zeal evidenced in fulfilling high office are extended the order.

Forty-two physicians from three Southeastern states participated the second week in November in a postgraduate course on "Musculoskeletal Problems in Children" at the Medical College of Georgia.

Medical college faculty with prominent roles in the course were GERALD H. HOLMAN, FRANK P. ANDERSON, JOHN L. CHANDLER, MARIO M. STONE, and H. BENTON BRIDGES.

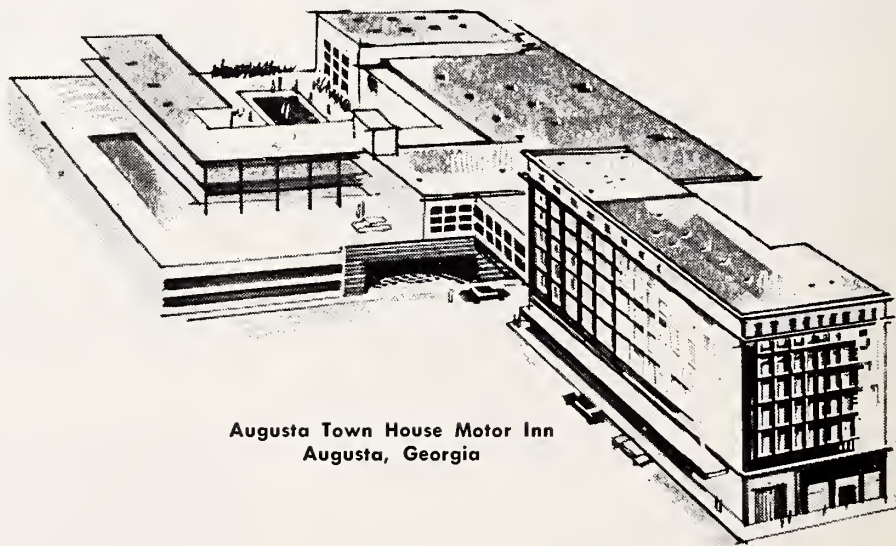
The course was coordinated by FLOYD E. BLIVEN, JR., and JAMES W. HARKESS, professor and associate professor respectively of orthopedic surgery.

## MOTIVATION FOR NEW DRUG RESEARCH

The purpose of drug investigation is to acquire and interpret reliable data which may either lead to practical medical conclusions about new therapeutic agents, or bring about a better understanding of the body systems and the ways in which disease affects them. The object is not to placate or please, to avoid controversy, or shun possible lawsuits, but to gain knowledge in the

interest of mankind. Acquisition of new knowledge, the finding of new cures, and the solving of some of the more stubborn mysteries in the health field, are what motivate the drug researcher.—Austin Smith, M.D., in *Experimental Medicine and Surgery*, 22: 2-3, (June-Sept.) 1964.

*Headquarters  
for the*



Augusta Town House Motor Inn  
Augusta, Georgia

111th Annual Session of the  
Medical Association of Georgia  
May 2-4, 1965



# CLASSIFIED ADVERTISING

**TWO MAN clinic** in community of 5,000 population, area population 20,000 or more. We have a modern clinic building with Hill-Burton Hospital affiliations. We desire one especially interested in obstetrics and/or pediatrics. If interested, please call Dr. J. C. Brim or Dr. W. C. Arwood at 294-2951 or 294-8146, The Pelham Clinic, Pelham, Ga., except on Tuesday and Saturday afternoon.

**PHYSICIAN'S OFFICE.** Modern Building. Gas Heat, Air Conditioning. Designed for medical practice, with waiting room, secretary's office, two examining rooms, laboratory, office-consult. room and located on large lot with spacious parking area on the edge of best residential area in University town. Ideal for general practitioner as practice has already been established by the departing G.P. Available now. For details call or write Mrs. Fred Randolph, 1010 Prince Ave., Athens, Ga., Phone 543-3060, Area Code 404.

**FOR SALE — 1963 Dodge Motor Home.** 14,000 BTU air conditioner, 5,000 watt generator. Completely equipped, 29,000 miles. \$8,900 or \$1,400 and assume loan. L. R. Cauthen, M.D., Floyd Hospital, Rome, Ga. 232-1247.

**PHYSICIAN'S OFFICE** available immediately, full or part time, vicinity of New DeKalb Hospital. For details call: Office—MEIrose 6-3296; Home—TRinity 5-1198.

**WANTED — General Practitioner** to be associated with three (3) man group in middle Georgia college town. Population approx. 15,000. Basic guarantee with new hospital facilities. Please refer to Box 392, JMAG, 938 Peachtree St., N.E., Atlanta, Ga. 30309.

**WANTED — General Practitioner** to join small clinic in Central Florida. Send reply to P. O. Box 546, Mount Dora, Florida.

CHARTER



MEMBER



CARL LICHTENHAHN

*Representing Professional Division*

*Associates in Every City — Established 1914*

**CREDITORS MERCANTILE & ADJUSTMENT AGENCY**

TELEPHONE JACKSON 1-2054 — — — SUITE 204-207 GRANT BUILDING

*"Hartrampf's Collection Service"*

ATLANTA, GEORGIA

## CALL FOR SCIENTIFIC EXHIBITS

**111TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA**

**Augusta, Georgia, May 2-4, 1965**

*For Information and Applications, Write to:*

**John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee**  
938 Peachtree Street, N.E. • Atlanta, Georgia 30309

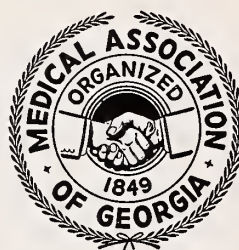
# Index of Advertising

VOL. 54

JANUARY 1965

No. 1

Allen's Hospital, Inc. . . . .	10A
Ames Co., Inc. . . . .	Third Cover
Appalachian Hall . . . . .	34A
Arnar-Stone Laboratories . . . . .	14A
(Chas. C. Haskell & Co., Div.)	
Atlanta Federal Savings & Loan Assn. . . . .	31A
Brawner Hospital, Inc. . . . .	34A
Brayten Pharmaceutical Co. . . . .	10A
Burroughs Wellcome Co. . . . .	4A; 21A
Citizens & Southern National Bank . . . . .	28A
Coca-Cola Bottlers' Assn. of Georgia . . . . .	2
Coca-Cola Co. . . . .	24A
Crawford W. Long Memorial Hospital . . . . .	26A
Creditors Mercantile & Adj. Agency . . . . .	39A
Dickey-Mangham Co. . . . .	37A
Eager & Simpson . . . . .	37A
Emory University Hospital . . . . .	26A
Geigy Pharmaceuticals . . . . .	10A, 11A; 15A
Georgia Baptist Hospital . . . . .	26A
Georgia Royal Crown Bottlers' Assn. . . . .	33A
Glenbrook Laboratories . . . . .	18A
Green Acres, Inc. . . . .	36A
The Henrietta Egleston Hospital for Children . . . . .	26A
Higgins-McArthur Co. . . . .	36A
Highland House, Inc. . . . .	35A
Hill Crest Sanitarium . . . . .	32A
Hynson, Westcott & Dunning . . . . .	1A
Insurance Specialists, Inc. . . . .	35A
Lederle Laboratories . . . . .	6A; 19A
Life of Georgia . . . . .	27A
Lilly, Eli & Co. . . . .	22A
Mathis Certified Dairy, R. L. . . . .	35A
Merrell, Wm. S. Co. . . . .	16A, 17A
Mitchell Motors . . . . .	37A
The New Orleans Graduate Medical Assembly . . . . .	30A
Northside Manor . . . . .	29A
Parke, Davis & Co. . . . .	Second Cover
Peachtree Hospital, Inc. . . . .	31A
Pfizer Laboratories . . . . .	3A; 5A; 7A, 8A, 9A
Piedmont Hospital . . . . .	26A
Pineworth, Inc. . . . .	32A
Plaza Pharmacy . . . . .	37A
Ponce de Leon Infirmary . . . . .	26A
Professional Printing Co. . . . .	30A
Reid-Provident Laboratories Inc. . . . .	29A
Robins, A. H. Co. . . . .	13A
Roche Laboratories . . . . .	Back Cover
Searle, G. D. & Co. . . . .	23A
Smith, Kline & French Labs . . . . .	25A
St. Joseph's Infirmary, Inc. . . . .	26A
Thompson Hospital, Inc. . . . .	36A
Touro Infirmary . . . . .	27A
U.S. Vitamin & Pharmaceutical Corp. . . . .	14, 15
Wallace Laboratories . . . . .	12A; 20A
Walter Ballard Optical Co. . . . .	35A
Winthrop Laboratories . . . . .	2A
Classifieds . . . . .	39A



THE

# Journal

OF THE

# MEDICAL ASSOCIATION OF GEORGIA

938 Peachtree Street, N.E. • Atlanta, Georgia 30309

**MANUSCRIPTS**—Articles are accepted for publication on the condition that they are contributed solely to this *Journal*. Manuscripts should be typewritten, double-spaced, and the *original and one copy should be submitted*. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

**STYLE**—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis, *Arch. Int. Med.*, 36:434 (Dec.) 1946.

**NEWS NOTES**—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

**REPRINTS**—Requests for reprints should be made directly to Mr. John S. McKenzie, Higgins-McArthur Company, 302 Hayden Street, N.W., Atlanta, Georgia 30313. Reprints must be ordered within 60 days after publication, since all type will be destroyed after that time.

**ILLUSTRATIONS**—Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings, and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

**GENERAL POLICY**—The Editor and members of The *Journal* Editorial Board will permit authors to have as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

**ADVERTISING**—All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the *Journal* office by 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

**MEDICAL EDITING SERVICE**—If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.



**JOURNAL**  
OF THE MEDICAL  
ASSOCIATION

FEBRUARY 1965  
*Georgia*



**AMA President Addresses  
Medical Leaders Conference**





epilepsy may limit  
opportunity...

## Dilantin<sup>®</sup> (diphenylhydantoin)

PARKE-DAVIS

### extends horizons

This agent "...has brought new hope to an entire generation of seizure patients...With judicious use, it may be said that it alone is responsible for the prevention of more seizures than any other drug."\*

DILANTIN (diphenylhydantoin) can help your epileptic patient to earn a livelihood...to prove his worth...and to share in the daily give-and-take as a full-fledged member of the workaday world.

*Indications:* Grand mal epilepsy and certain other convulsive states.

*Precautions:* Toxic effects are infrequent: allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Eruptions then usually subside. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia, aplastic anemia, leukopenia, granulocytopenia and pancytopenia have been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Periodic examination of the blood is advisable.

DILANTIN (diphenylhydantoin sodium) is supplied in several forms including Kapseals<sup>®</sup> containing 0.1 Gm. and 0.03 Gm.

\*Roseman, E.: *Neurology* 11:912, 1961.

33664

**PARKE-DAVIS**

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232



JOURNAL  
OF THE MEDICAL  
ASSOCIATION

Georgía

Contents

EDITOR

Edgar Woody, Jr., M.D.

MANAGING EDITOR

Merrilie M. Davis

STAFF

Thelma V. Franklin, Business

CONTRIBUTING EDITORS

Herbert S. Alden, M.D.; Preston D. Ellington, M.D.; Thomas Findley, M.D.; J. Willis Hurst, M.D.; Charles S. Jones, M.D.; Arthur M. Knight, Jr., M.D.; Arthur J. Merrill, M.D.; Lester Rumble, Jr., M.D.; Peter L. Scardino, M.D.; Patrick C. Shea, Jr., M.D.; Robert H. Vaughan, M.D.

PUBLICATIONS COMMITTEE

J. G. McDaniel, M.D.; George H. Alexander, M.D.; George R. Dillinger, M.D.; John Kirk Train, M.D.; A. W. Simpson, M.D.; John T. Mauldin, M.D.; John S. Atwater, M.D.; C. R. Andrews, M.D.

THE ASSOCIATION

J. G. McDaniel, M.D., Pres.; George H. Alexander, M.D., Pres.-Elect; George R. Dillinger, M.D., Past Pres.; A. W. Simpson, M.D., Chm. of Council; John T. Mauldin, M.D., Sec.; John S. Atwater, M.D., Treas.; J. Frank Walker, M.D., Speaker; Mr. Milton D. Krueger, Exec. Sec.; Mr. James M. Moffett, Asst. Exec. Sec.; Mrs. Catherine Wooten, Asst. Exec. Sec.

THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and copyrighted, 1965, by the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309. Published monthly under the direction of the Council of the Association. Subscription rate: \$7 per year; \$1 per single copy. Second-class postage paid at Atlanta, Georgia.

Scientific Articles

SPONTANEOUS RETURN OF FUNCTION OF FACIAL MUSCLES FOLLOWING RADICAL EXCISION OF PAROTID CARCINOMA William E. Schatten, M.D.; William G. Hamm, M.D., and Joseph H. Patterson, M.D. . . . .	33
THE DIFFERENTIAL DIAGNOSIS OF LEFT VENTRICULAR — RIGHT ATRIAL SHUNTS Hurley D. Jones, M.D. and Robert H. Franch, M.D. . . . .	38
ANKLE INJURIES Chestley L. Yelton, M.D. . . . .	41
STENOSIS OF THE URETHRAL MEATUS William H. Bennett, M.D.; William N. Morrison, M.D., and Ted L. Staton, M.D. . . . .	46
HEREDITARY MUSCULAR ATROPHY Waldo E. Floyd, Jr., M.D. . . . .	48
THE TREATMENT OF FELONS James E. Anthony, Jr., M.D. . . . .	50

Editorials

IN APPRECIATION . . . . .	52
THE NEW 1965 AMA LEGISLATIVE PROPOSAL ON HEALTH CARE OF THE AGED . . . . .	52
THE TUNE IS THE SAME . . . . .	53
WHAT DID THE PAC MOVEMENT CONTRIBUTE IN '64 ELECTIONS? PLENTY, SAY CANDIDATES . . . . .	54

Features

President's Letter . . . . .	55	Societies . . . . .	62
Cancer Page . . . . .	56	Personals . . . . .	63
Heart Page . . . . .	58	Advertising Index . . . . .	40A

The Association

Deaths . . . . .	62	Calendar . . . . .	57
------------------	----	--------------------	----

Cover

Dr. Donovan Ward, President, American Medical Association, speaking to the Medical Leaders Conference, January 17, 1965, Atlanta. Photography, Tracy O'Neal, Atlanta.



*Now... your patients can enjoy  
new Diet-Rite Cola!*

**FULL COLA PLEASURE...  
NO SUGAR AT ALL!**



New Diet-Rite Cola, with no sugar at all, contains only one calorie in each 6-ounce serving. Yet, Diet-Rite Cola retains full, rich cola taste... refreshing cola pleasure! And the  $pH$  of this product, about 2.6 to 2.8, represents the same general range of acidity as other cola beverages and a number of fruit juices.

Diet-Rite Cola is a beverage you and your patients will like... and go on liking. And... Diet-Rite Cola is available at no extra cost.



**diet-rite® cola**

**A product of Royal Crown Cola Co.**

*Also available in handy cans.*



# SPONTANEOUS RETURN OF FUNCTION OF FACIAL MUSCLES FOLLOWING RADICAL EXCISION OF PAROTID CARCINOMA

William E. Schatten, M.D.

William G. Hamm, M.D.

Joseph H. Patterson, M.D., *Atlanta*

## ■ *An unusual case in a five year old female is reported.*

THERE HAS BEEN a good deal of recent interest in the spontaneous return of function of facial muscles following surgical section or excision of the facial nerve. Martin and Helsper<sup>1,2</sup> reported that spontaneous return of function occurs due to establishment of new pathways by way of the V cranial nerve. James and associates<sup>3</sup> demonstrated experimentally that return of VII nerve function can occur after wide excision of the nerve in dogs. Reinnervation was shown by physiologic and histologic studies to be due to spontaneous regeneration of VII nerve fibers and there was no evidence of anastomosis between the VII and V cranial nerves. Kettel<sup>4</sup> reported he has not observed VII nerve regeneration in patients, and states that repair of a severed facial nerve should not even be prolonged one year to see if spontaneous return of function will occur. Conley<sup>5</sup> reported he had not seen VII nerve regeneration in adults but in each of two children, aged five and seven, there was approximately 90% spontaneous recovery of function of the face within 12 months following resection of approximately 50 mm. of facial nerve. This is a report of spontaneous return of function of facial muscles following wide resection of the VII nerve in a five-year-old female.

P.M., a 5½-year-old white female, was admitted to the Henrietta Egleston Hospital for Children on March 10, 1960, because of a painless enlarging mass in the right parotid gland region. The patient's mother first noticed the presence of swelling in this area eight weeks prior to admission.

Past history was significant in that the patient

developed multiple hemangiomas involving the lower lip, right and left cheeks, and upper portions of the right and left sides of the neck shortly after birth on August 5, 1954. At seven weeks of age, 25 gold radon seeds, each containing 0.1 mc. of radon, were implanted into the hemangiomas on the left cheek, lower lip, chin, right cheek, and neck. Two months later, the hemangiomas increased in size and these were treated by external irradiation. Superficial irradiation was delivered over the face and neck at intervals of one week between November 17, 1954, and December 1, 1954, the patient receiving 600 R to the left posterior cheek and anterior external ear, 600 R to the left anterior cheek, 600 R to the chin and lower lip, and 600 R to the right cheek and neck. In addition, two small hemangiomatous areas on the right ear were treated with a Strontium applicator on December 1, 1954. Each of these areas received 400 R. A second series of low voltage x-ray therapy was given through two separate portals to the hemangiomas of the face between January 5, 1955, and January 9, 1955, the patient receiving 600 R to the right lower ear, postauricular region and posterior cheek and 600 R to the right anterior cheek.

Pertinent physical findings were limited to the head and neck. The skin over the right side of the neck and lower lip was discolored and there was thickening of the lower lip. The patient had normal movement of muscles of facial expression. There was a nontender mass measuring approximately 2 cm. in diameter below the lobe of the right ear. The mass was freely movable and not attached to the skin. There were other small glands palpable along

*Presented at the 110th Annual Session of the Medical Association of Georgia, May 5, 1964, Macon, Georgia.*



the anterior border of each sternocleidomastoid muscle and in the submaxillary areas bilaterally.

On March 15, 1960, under endotracheal anesthesia, the parotid tumor was dissected from surrounding structures, care being taken to preserve the facial nerve. After dissection of the bulk of the mass, it was seen that there was a small remaining portion that was intimate with multiple branches of the facial nerve and it would be necessary to resect a portion of the nerve in order to resect the entire tumor. A biopsy was then sent for frozen section and a diagnosis was made of probable mucoepidermoid carcinoma. It was decided not to sacrifice the facial nerve by performing a radical excision at this time because of the benign clinical course of many patients with this tumor. There was no weakness of muscles of facial expression postoperatively and recovery was uneventful.

### Histologic Study

Histologic study of permanent sections revealed a mucoepidermoid carcinoma and fibrosis and chronic inflammation of salivary gland. There were extended areas of scarring with dilated ducts, atrophic acini and a diffuse chronic inflammatory infiltrate in portions of salivary gland not involved by tumor. There was an indistinct transition between this salivary gland tissue and an adjacent malignant tumor composed in part of squamous or squamous-like elements and in others by glandular and mucous producing cells. The cells showed mild pleomorphism and infrequent mitoses and the tumor appeared well differentiated. Small nests, particularly of the squamous type of epithelium, were infiltrating between areas of the salivary gland and the tumor was considered to be invasive. Fibrosis and chronic inflammation in salivary gland not involved by carcinoma were thought to be the result of previous irradiation.

Two and one-half months following tumor resection a nontender palpable mass became apparent in the parotid region. There was no associated pain in the face and no evidence of facial nerve weakness.

On June 14, 1960, under endotracheal anesthesia, a radical *en bloc* excision of the recurrent tumor was performed. The entire tumor mass, including masseter muscle, was removed without regard to the facial nerve; excision of a block of all soft tissue in this region was carried down to the anterior surface of the mandible. There were several large nodes in the posterior portion of the digastric triangle and a group of these nodes was removed separately for diagnostic purpose. There was an uneventful post-

operative course. The patient had complete loss of movement of muscles of facial expression on the right side.

Histologic study showed that the tumor was a mucoepidermoid carcinoma made up of two elements, one being mucin-producing cells and the other being squamous changes within ducts. The tumor infiltrated locally into the surrounding stroma. The margins of excision were free of tumor. Sections of masseter muscle showed only a slight inflammatory infiltrate. There was one lymph node included in the main mass of tumor with surrounding tissue and this was a hyperplastic node that did not reveal any evidence of metastatic tumor. Three lymph nodes removed from the upper digastric triangle revealed marked hyperplasia with no evidence of metastatic tumor.

Sections of the tumor removed at this operation and also at the operation three months previously were reviewed by several pathologists in this area. It was the consensus that the histologic features of this particular mucoepidermoid carcinoma were of intermediate malignancy.

The patient is continuing to be followed at frequent intervals and there is no evidence of recurrent tumor locally or at distant sites at the time of this report four years following operation.

Six months postoperatively there was definite return of voluntary movement of facial muscles. There was progressive improvement during the next six months and at the present time there is little asymmetry.

### Discussion

The appearance of the face prior to radical tumor resection is shown in Figure 1. Facial nerve paralysis is demonstrated in Figures 2 and 3, taken two months postoperatively. Widening of the palpebral fissure and distortion of the face when smiling can be noted in these photographs. The patient had continual tearing. Comparison of these photographs with those of Figures 4 and 5, taken 5½ months later, reveals demonstrable improvement in facial muscle function. Comparison of Figure 6 with Figures 7, 8 and 9 shows further improvement over a 4½ month period.

Recovery of facial movement was progressive. Return of voluntary movement in the lower lip and right commissure of the mouth was first noted six months postoperatively. Six weeks later she was able to bring the right commissure of her mouth laterally almost as far as the left side although there was weakness on closing the right eye and there was no movement of the frontalis muscle. Innervation of the orbicularis oculi and frontalis muscles was the last to return.





**FIGURE 1**  
Prior to VII nerve paralysis (June, 1960)



**FIGURE 2**  
VII nerve paralysis; 2 months postoperatively

Mucoepidermoid tumors of salivary glands were described by Stewart and his associates.<sup>6</sup> Since this description, there has been a great deal of discussion regarding the histological classification of these tumors and their clinical courses. In some reports of patients with these tumors the extremely favorable course has prompted clinicians to question true malignancy. Many authors regard these to be relatively benign salivary gland duct neoplasms in which the lining epithelium undergoes marked squamous and mucous metaplasia and they consider the more malignant variant of mucoepidermoid tumor described by Stewart and associates to be either undifferentiated adenocarcinomas or adenoacanthomas of salivary gland origin. There are pathologists who believe they can prognosticate the course of mucoepidermoid tumors by their histologic appearance and this information is used by some clinicians as a basis for decision regarding therapy. There are other reports of patients with mucoepidermoid carcinomas who develop metastases and die from this disease.

The relationship between external irradiation in infants and the development of thyroid carcinoma is fairly well established. This patient received a total of 5400 R for treatment of hemangiomas of the face and upper neck between the ages of seven weeks and five months. The relationship between



**FIGURE 3**  
VII nerve paralysis; 2 months postoperatively





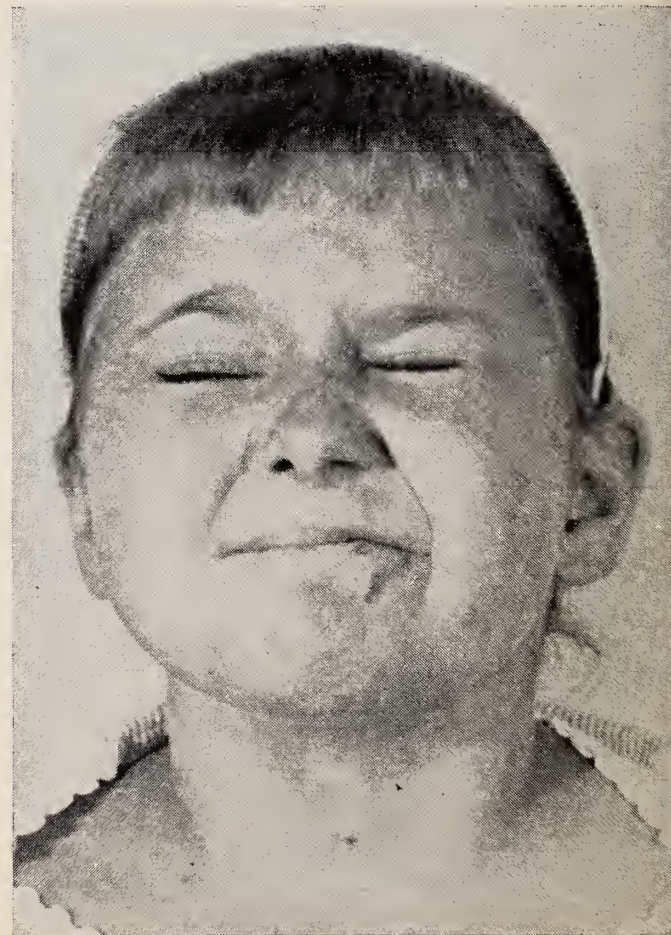
FIGURE 4 VII nerve paralysis; 7½ months postoperatively



FIGURE 5



FIGURE 6  
7½ months postoperatively



VII nerve paralysis

FIGURE 7  
1 year postoperatively





**FIGURE 8** VII nerve paralysis  
1 year postoperatively



**FIGURE 9**

this amount of irradiation and the development of mucoepidermoid carcinoma of the parotid gland is conjectural.

**Summary**

This is a report of a five-year-old female who developed mucoepidermoid carcinoma of the parotid gland. Radical excision with sacrifice of the facial nerve was followed by complete right-sided facial paralysis. Return of facial muscle function began six months postoperatively and was progressive during the next six months. There was little noticeable asymmetry one year postoperatively. There has been no evidence of recurrent tumor during the four-year period since operation.

701 Peachtree Street, N.E.

**BIBLIOGRAPHY**

1. Martin, H. and Helsper, J. T.: Spontaneous Return of Function Following Surgical Section or Excision of the Seventh Cranial Nerve in the Surgery of Parotid Tumors, *Ann. Surg.* 146:715, 1957.
2. Martin, H.: Supplementary Report on Spontaneous Return of Function Following Surgical Section or Excision of the VII Nerve in Surgery of Parotid Tumors, *Ann. Surg.* 151:538, 1960.
3. James, A. G.; Karlan, M.; Kinsey, D. L., and Meagher, J. M.: Spontaneous Regeneration of the Seventh Nerve, *A.M.A. Arch. Surg.* 81:223, 1960.
4. Kettel, K.: Surgical Repair Versus Expectant Therapy in Traumatic Facial Palsy, *Arch. Otorhinolaryng.* 71:623, 1960.
5. Conley, J. J.: Facial Nerve Grafting in Treatment of Parotid Gland Tumors, *A.M.A. Arch Surg.* 70:359, 1955.
6. Stewart, F. W.; Foote, F. W., and Becker, W. F.: Muco-epidermoid Tumors of Salivary Glands, *Ann. Surg.* 122:821, 1945.

**NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA**

NAME	ADDRESS	NAME	ADDRESS
Glover, Ridley M. Active—Laurens	Laurens Memorial Hospital Dublin, Georgia	Snell, John Edward Active—Fulton	80 Butler St., S.E., Box 26067 Atlanta, Georgia
Holmes, William C. Active—Bartow	41 Nelson Street Cartersville, Georgia	Vigil, Ramon A. Active—Ware	Memorial Hospital Waycross, Georgia
Meriwether, Thomas W., III Active—Cobb	502 Cherokee Street Marietta, Georgia	Wick, Quintin J. Service—Laurens	VA Center Dublin, Georgia
		Williams, H. Grady, Jr. Active—Cook-Berrien	703½ N. Davis Street Nashville, Georgia



# THE DIFFERENTIAL DIAGNOSIS OF LEFT VENTRICULAR — RIGHT ATRIAL SHUNTS

Hurley D. Jones, M.D.,  
Robert H. Franch, M.D., *Atlanta*

## ■ *The authors' experience with four cases is outlined.*

**I**NTRODUCTION: The purpose of this communication is to report four additional cases of left ventricular-right atrial shunts and to discuss the nomenclature, diagnosis and treatment. Such shunts should be considered in any patient with a holosystolic murmur at the lower left sternal border and a right atrial oxygen stepup.

### Classification

Left ventricular-right atrial shunts can be divided into two principal varieties. The first type is made possible by a defect in the atrioventricular septum as seen in Figure 1, diagram A. This septum forms the floor of the right atrium and lies superior to the tricuspid valve. We have thus referred to these as supravulvular shunts.

The second type of left ventricular-right atrial shunt is anatomically different from that described above. It consists of a ventricular septal defect (VSD) in combination with a malformed tricuspid valve.<sup>1</sup> The abnormality of the valve may consist of a perforation of the septal leaflet, short leaflets, cleft leaflets or malpositioned chordae tendineae. This combination of anatomical circumstances allows blood to be ejected from the left ventricle through the VSD point blank into the valvular defect and thence the right atrium. We have referred to these as left ventricular-right atrial shunts of the VSD-tricuspid type. Such a shunt is depicted in Figure 1, diagram B. In a significant number of such patients, one or more of the leaflets of the tricuspid valve becomes plastered to the rim of the VSD.<sup>2</sup> Adherence to the complete circumference of the VSD as in Figure 1, diagram C leads to delivery

of the entire shunt into the right atrium. In cases where no adherence or incomplete adherence is present, a portion of the shunted blood is delivered to the right ventricle as well as to the right atrium and oxygen stepups may occur in both chambers.

This report describes four patients with left ventricular-right atrial shunts. Case One and Case Two are of the supravulvular variety, each having a defect in the atrioventricular septum allowing blood to shunt directly from the left ventricle to the right atrium. Table I (page 40) summarizes the clinical and laboratory data of these two patients as well as that of patients Three and Four who have shunts of the VSD-tricuspid variety. In each of the latter patients, surgery revealed that the septal leaflet of the tricuspid valve was partially adherent to the rim of the ventricular septal defect. Blood ejected through the VSD was noted to enter the right atrium through the commissure between the septal and posterior leaflets.

### No Evidence

The patients with supravulvular shunts had Grade 3-4 systolic murmurs and thrills of maximal intensity at the lower left sternal border. In both patients, the point of maximal intensity was slightly outside the midclavicular line and a sustained apical impulse was present. Neither had evidence of congestive heart failure.

The two patients with VSD-tricuspid shunts likewise had grade 3-4 systolic murmurs and thrills maximal at the lower left sternal border. Both patients had evidence of cardiac enlargement either on the physical examination or chest x-ray and Case Number Three had symptoms suggestive of congestive failure prior to surgery.

The patients with supravulvular defects each had

Presented at the 110th Annual Session of the Medical Association of Georgia, May 4, 1964, Macon, Georgia.



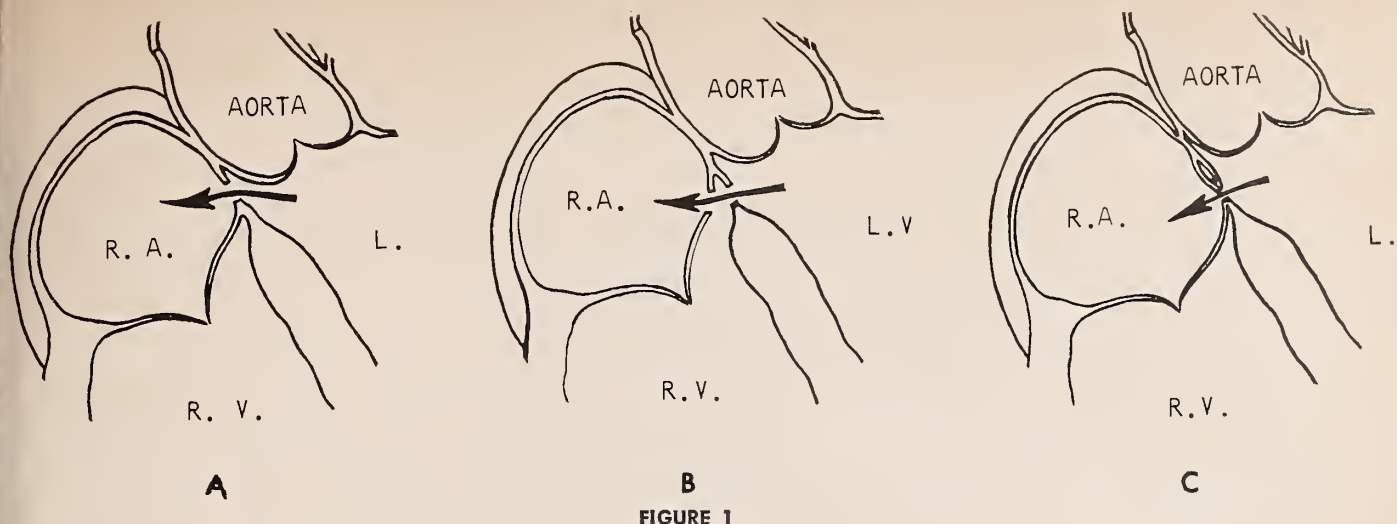


FIGURE 1

electrocardiograms with voltage compatible with left ventricular hypertrophy. The P waves were normal in both cases. Case One had a slightly prolonged PR interval and a QRS interval of .10 with incomplete right bundle branch block.

Each of the patients with VSD tricuspid shunts had evidence of biventricular hypertrophy. Both had high voltage splintered R waves in lead  $V_1$  and Case Number Four had P waves suggestive of right atrial enlargement.

#### Roentgenograms

Chest roentgenograms in each of these patients revealed increased pulmonary vascularity and a prominent pulmonary artery segment. Definite cardiac enlargement was present in three of the patients, Case Number Two having a heart of borderline size. Interstitial pulmonary edema was reported in patient Number Three on at least one occasion.

#### Cardiac Catheterization

All patients had definite oxygen stepups in the right atrium. The fourth case had an additional stepup in the right ventricle.

None of the four patients had elevation of the right atrial pressure, nor was a prominent V-wave present. Others have found the mean right atrial pressure to be normal in patients with left ventricular-right atrial shunts.<sup>3</sup> A normal pressure is made possible by the presence of an enlarged, distensible right atrium which is in communication with the capacious low pressure venous reservoir of the great veins that serve as a pop-off valve.<sup>3</sup>

The pulmonary artery pressures and the pulmonary vascular resistances were normal in the patients with supraventricular shunts. The pulmonary flows in these two patients were 3.2 and 1.9 times systemic flow respectively. The two patients with VSD-tricuspid shunts had moderately elevated pulmonary artery pressures, normal pulmonary vascular resistances and pulmonary flows of 4.7 and 3.3 times systemic respectively.

Conditions with a holosystolic murmur and a right atrial oxygen stepup that are likely to be confused with left ventricular-right atrial shunt include ostium primum defects, combination ASD-VSD and a ventricular septal defect with associated partial anomalous venous return. The course of the catheter during cardiac catheterization is helpful in making the distinction between left ventricular-right atrial shunt and these conditions. The catheter tip can be placed across a primum or secundum type of atrial septal defect in a large percentage of cases, but in our experience the defect responsible for a left ventricular-right atrial shunt has not been catheterized. Selective left ventricular angiography is the procedure upon which definitive diagnosis rests.<sup>4</sup> If it can be firmly demonstrated that opaque media injected into the left ventricle shunts directly to the right atrium, the diagnosis is established.

#### Treatment

Left ventricular-right atrial shunts are often surgically correctable. With the use of a heart-lung bypass, the supraventricular defects can be closed from the right atrium under direct vision. Insofar as the VSD-tricuspid shunts are concerned, the ventricular septal defect can be closed, but whether or not the tricuspid valve abnormality is amenable to repair depends on the particular type of valvular defect present. Each of the four cases in this report have had their lesions corrected and are doing well clinically at the present time. Case One was restudied by catheterization a year postoperatively and the hemodynamics were entirely normal.

Emory University School of Medicine

#### REFERENCES

1. Edwards, J. E.: Left Ventricular-Right Atrial Communication, *Gould's Pathology of the Heart*, ed. 2, Springfield, C. C. Thomas, p. 302, 1960.
2. Perry, E. L.; Burchell, H. B., and Edwards, J. E.: Congenital Communication between the Left Ventricle and

Left Ventricular – Right Atrial Shunts/Jones and Franch

TABLE 1  
CLINICAL AND LABORATORY DATA SUMMARIZING FOUR PATIENTS  
WITH LEFT VENTRICULAR–RIGHT ATRIAL SHUNTS

Patient	Type Shunt	Age	Race Sex	Murmur	Systolic Thrill	Apical Impulse	Second Sound
Na. 1	Supravalvular	23 yrs.	W/F	Grade 3/6 *systolic murmur maximal lower left Sternal border	Yes	Outside MCL and sustained	
No. 2	Supravalvular	7 yrs.	W/F	Grade 3/6 halasystolic murmur maximal lower left sternal bader	Yes	Outside MCL and sustained	Persistent splitting
Na. 3	VSD-Tricuspid	6 mas.	W/M	Grade 4/6 *systolic murmur maximal lower left sternal border	Yes	Outside MCL and sustained	Second saund laud, physiologic splitting
Na. 4	VSD-Tricuspid	9 yrs.	W/M	Grade 4/6 halasystolic murmur lower left sternal boarder	Yes	Outside MCL and sustained	Physiological splitting

(continued)

Patient	Heart Failure	Chest Roentgenagram	EKG	Catheterization Data
Na. 1	Na	Increased pulmonary vascularity, Praminent pulmanary artery segment, cardiac enlargement	IRBBB, LVH, normal P waves, PR interval—.21 sec., electrical axis normal	17.6% oxygen stepup between SVC and MRA, MPA=28/12 PF=3.2 x SF
Na. 2	Na	Increased pulmanary vascularity, Barderline heart size	Normal camplex in lead V-1 LVH, normal P waves, normal PR interval, electrical axis normal	13.6% oxygen stepup between SVC and MRA, MPA=30/10 PF=1.9 x SF
Na. 3	Yes	Increased pulmanary vascularity, Praminent pulmanary artery, Biventricular enlargement, Left atrial enlargement	Lead V <sub>1</sub> splintered with tall R wave, Biventricular hypertrophy, large P waves, normal PR interval, electrical axis normal	21.2% axygen stepup between SVC MRA, MPA=54/17 PF=4.7 x SF
Na. 4	Na	Increased pulmanary vascularity, Praminent pulmanary artery segment, maderate cardiamegaly	Lead V <sub>1</sub> splintered with tall R wave, prabable biventricular hypertrophy, normal P wave, normal PR interval, superiarly directed electrical axis	9.8% oxygen stepup between SVC and MRA, 12% axygen stepup betw LRA and HRV, MPA=56/14 PF=3.3 x SF

\*No information available on duration of murmur.

the Right Atrium, *Proc. Staff Meet., Mayo Clinic*, 24:198, 1949.

3. Gerbode, F.; Hullgren, H.; Melrose, D., and Osborne, J.: Syndrome of Left Ventricular-Right Atrial Shunt, Successful Surgical Repair of Defect in Five Cases, with Ob-

servation of Bradycardia on Closure, *Ann. Surg.*, 148:433, 1958.

4. Braunwald, E.; Morrow, A. G., and Cooper, T.: Left Ventricular Angiocardiology in the Diagnosis of Persistent Atrioventricular Canal and Related Anomalies, *Am. J. Cardiol.*, 4:202, 1959.

CALL FOR SCIENTIFIC EXHIBITS  
111TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA  
Augusta, Georgia, May 2-4, 1965

For Information and Applications, Write to:  
John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee  
938 Peachtree Street, N.E. • Atlanta, Georgia 30309



# ANKLE INJURIES

Chestley L. Yelton, M.D., *Birmingham, Alabama*

- **History of the injury is of primary importance and will usually reveal its mechanism.**

**I**NJURIES ABOUT THE ANKLE may be minor or major in nature. Sprains or partial ligamentous ruptures are usually classified as minor injuries while fracture and complete ligament rupture, alone or in combination, are considered major injuries. Roentgenographic examination in the anteroposterior, lateral, and 30 degree internal oblique projections are essential and will, in the majority of fractures, demonstrate the extent and configuration of all major fragments. If there is any question, other oblique projections should be obtained. If the injury appears to be major and no fracture is demonstrable, the question of the existence of ligamentous rupture in doubtful cases may be resolved by obtaining anteroposterior roentgenograms in eversion or inversion stress.

## Treatment

All ankle sprains are treated by prohibition of weight bearing, application of cold compresses, compression for control of hemorrhage and hematoma formation, rest and elevation. Re-evaluation of the injury on the second day is necessary in order for one to make any reasonably accurate estimation as to the probable length of disability. The studies of Quigley<sup>6</sup> indicate that the most frequent injury to the ankle is a sprain of the anterior tibiofibular and fibulotalar ligaments and that when properly and conservatively treated will be sufficiently healed in eight to ten days to permit resumption of normal activity.

Complete ligamentous rupture of the fibular collateral, the deltoid or the inferior tibiofibular ligament may occur. Internal rotation—adduction forces, may rupture the fibular collateral ligament. This injury necessitates immobilization in plaster with the ligament in a position of relaxation. Many surgeons feel that primary suture of this ligament

is justified. In light of our knowledge of the results obtained by initial suture of ruptured ligamentous structures at the knee, this form of initial treatment is being more and more frequently performed about the ankle. The laboratory studies of Clayton and Weir<sup>2</sup> indicate that initial suture of ruptured ligaments is much superior to that of closed treatment.

Abduction forces may rupture the deltoid ligament. Initial suture is indicated. On occasions, roentgenographic examination will reveal a tiny fracture of the distal tip of the medial malleolus. Do not be lulled into a sense of security by this minor fracture as it represents, in all probability, a rupture of the deltoid ligament. Initial treatment should be suture of the ligament. The small fragment may be discarded. Forced abduction may rupture the inferior tibiofibular and interosseous ligaments resulting in a tibiofibular diastasis. The bones may spring back into position and, if so, the roentgenogram will appear negative. In this instance, unless anteroposterior roentgenograms are made in the position of abduction stress, the diagnosis will be missed. Diastasis of the inferior tibiofibular articulation, with or without rupture of the deltoid ligament, is treated in plaster with the malleoli carefully compressed or by internal fixation by a screw through the fibula into the tibia or by a bolt that traverses that joint. The screw or bolt should always be removed as there is normally some movement in the tibiofibular joint.

## Indirect Violence

Indirect violence resulting in excessive forces being applied to the osseoligamentous structures comprising the ankle joint may result in fractures and fracture dislocations of this joint. These forces are external rotation, abduction, adduction, vertical compression or a combination of two or more of these causative traumas.

Presented at the 110th Annual Session of the Medical Association of Georgia, May 3, 1964, Macon, Georgia.





**FIGURE 1 A and B**

A, film taken immediately after posterior dislocation of the ankle. The fibula has accompanied the talus posteriorly. The tibio-fibular, interosseous and deltoid ligaments are ruptured. B, post-operative film made nine months following reduction of dislocation and primary suture of deltoid ligament.

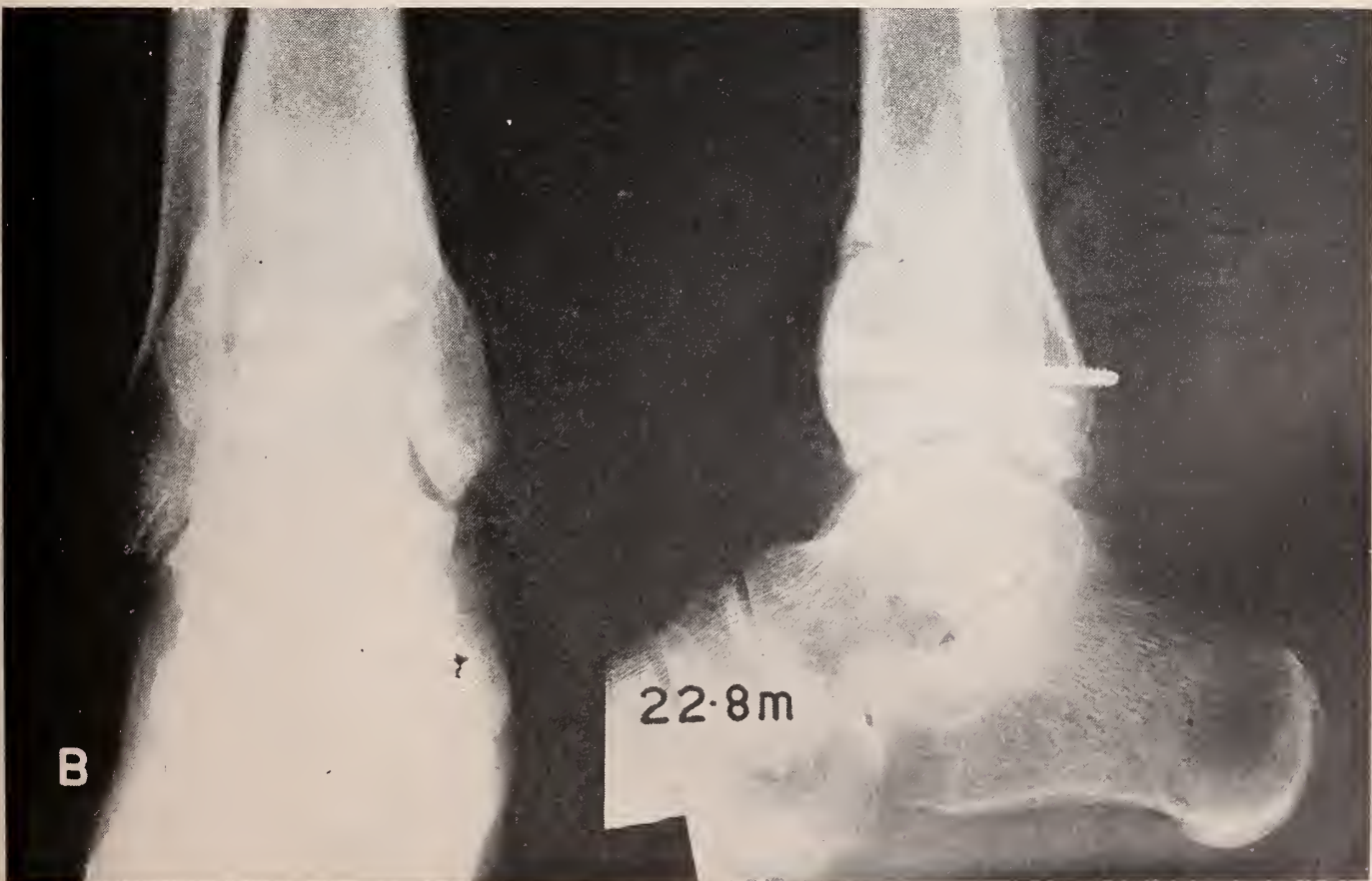






**FIGURE 2 A and B**

A, film taken immediately after compression-pronation external rotation injury. B, postoperative film made eight months following open anatomical reduction and fixation of the large distal tibial fragment with two screws.





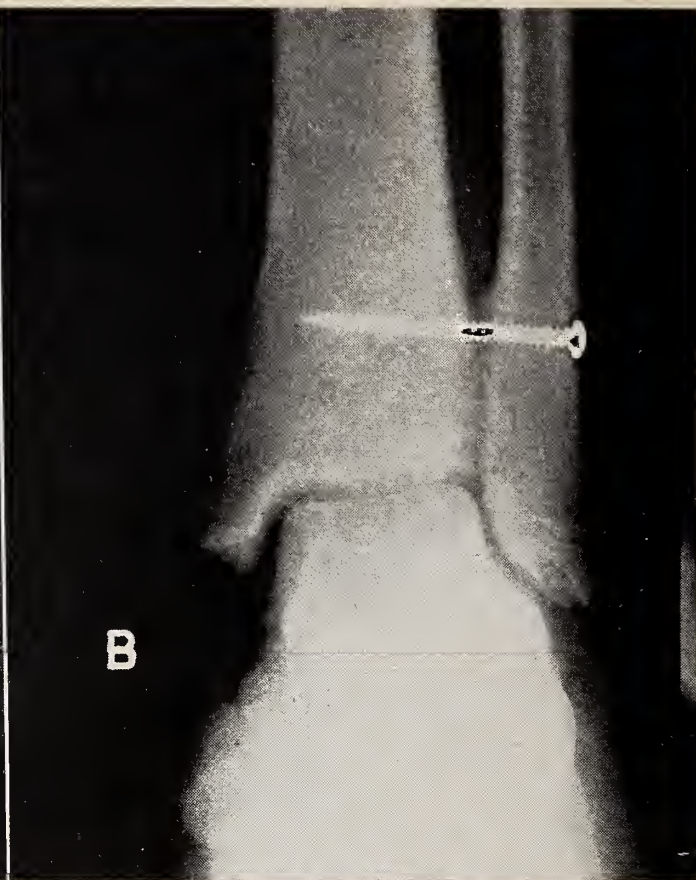
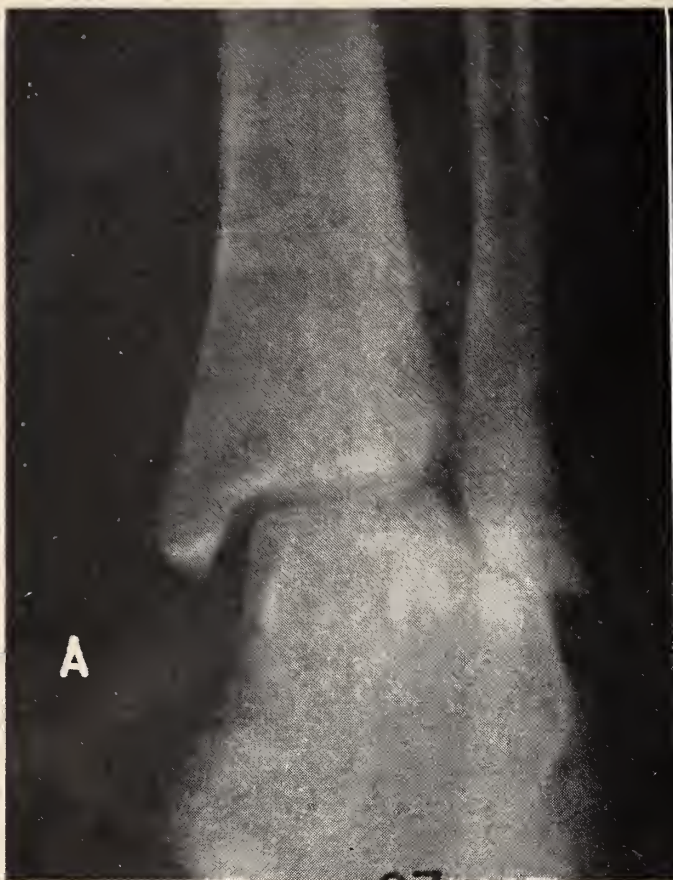


FIGURE 3

A, film taken following external rotation injury. Space between talus and medial malleolus could be lessened by closed manipulation. B, postoperative film taken one year after trapped deltoid ligament had been removed from joint and the mortise restored

by a screw. The patient declined having the screw removed at an earlier date. Screws or bolts should always be removed as there is normally some motion in the tibiofibular joint.

Most classifications are based upon the mechanism causing the injury. Lauge-Hansen<sup>3,4</sup> divided these injuries into five major categories with 17 subtypes and pointed out that an analysis of the combination of forces producing the various types of malleolar fracture will enable one to determine the existence of accompanying ligamentous ruptures which otherwise might be overlooked. An understanding of the functional anatomy of the ankle plus other diagnostic criteria will enable one to make an accurate diagnosis which is essential in treating these injuries. A very careful analysis of every ankle injury must be carried out. History of the injury is most important and will usually reveal its mechanism. What appears to be a simple fracture without displacement may have been a fracture with gross displacement which has spontaneously reduced or one where the deformity has been corrected by the x-ray technician prior to the making of roentgenograms.

#### Anything Less—Impairment

Anything less than anatomical reduction of closed fractures and dislocation of the ankle region may result in prolonged morbidity and permanent impairment of function. Many fractures and fracture dislocations cannot be reduced anatomically by closed methods because of interposition of soft tissue

or small fragments of bone and cartilage and will require open reduction and internal fixation. Bosworth<sup>1</sup> has described a type of fracture where the proximal fragment of the fibula is displaced and locked behind the postero-lateral margin of the tibia. Open reduction is necessary for replacement.

If there is widening of the ankle mortise and the talus cannot be replaced against the medial malleolus by manipulation, then one should suspect trapping of the deltoid ligament or of the posterior tibial tendon between the talus and medial malleolus as described by Lee and Horan.<sup>5</sup> This trapping of the tendon can occur if released by an avulsion of the tip of the medial malleolus or by a tear of the deltoid ligament. This condition requires open operation, replacement of the tendon followed by repair of the ligament or fixation of the malleolus.

Growth arrest and distortion of the weight-bearing alignment of the limb, ankle, and foot follow certain epiphyseal fractures of the lower end of the tibia that occur in children. These fractures should not be surgically approached. They should not be forcefully or repeatedly manipulated. Any further damage to the epiphyseal plate is to be avoided.

#### Summary

Only anatomical reduction of closed fractures and



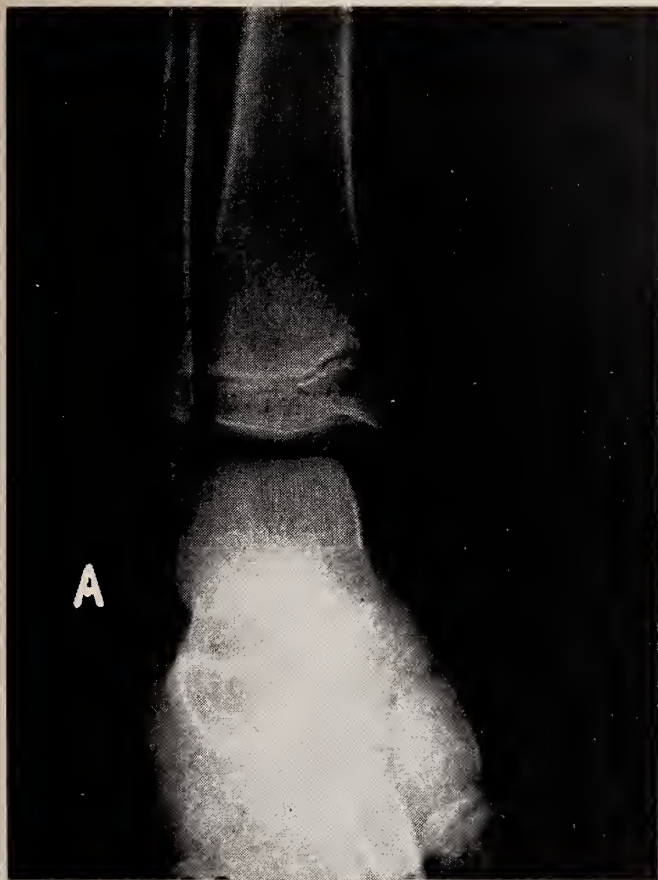


FIGURE 4

A, film taken immediately after a compression type injury to the medial portion of the distal tibial epiphysis.

B, film taken two and one-half years following injury, illustrating the end result of loss of growth and distortion of the weight-bearing alignment of the limb, ankle and foot.

dislocations of the ankle are compatible with good function of the joint. Any disturbance of the normal relations of the ankle mortise, irregularity of articular surfaces, or loss of normal weight-bearing alignment may result in a disabling post-traumatic arthritis. Open reduction and internal fixation should be carried out if anatomical reduction cannot be obtained and maintained by closed methods.

619 South 19th Street

#### REFERENCES

1. Bosworth, D. M.: Fracture-Dislocation of the Ankle

with Fixed Displacement of the Fibula Behind the Tibia, *J. Bone & Joint Surg.*, 29:130-135 (Jan.) 1947.

2. Clayton, M. L., and Weir, G. J.: Experimental Investigation of Ligament Healing, *Am. J. Surg.*, 98:373-378 (Sept.) 1959.

3. Lauge-Hansen, N.: Fractures of the Ankle, *Arch. Surg.*, 64:488-500 (April) 1952.

4. Lauge-Hansen, N.: Fractures of the Ankle, *Arch. Surg.*, 67:813-820 (Dec.) 1953.

5. Lee, H. G., and Horan, T. B.: Internal Fixation in Injuries of the Ankle, *Surg. Gynec. & Obst.*, 76:593-599 (May) 1943.

6. Quigley, T. B.: Management of Ankle Injuries Sustained in Sports, *J. A.M.A.*, 169:1431-1436 (March 28) 1959.

## "A SMILE IS TO KEEP — WITH GOOD DENTAL HEALTH"

National Children's Dental Health Week, February 7-13, sponsored by the American Dental Association, is a concerted effort on the part of the nation's dentists to make not only children and their parents aware of the importance of good dental health, but also to request the help of their professional colleagues, the doctors, in detecting any oral diseases which may affect the overall health of the child.

There are several points on which the pediatrician may base his dental recommendations while examining the young patient.

(1) Children should see a dentist at two years of age, and thereafter, at least every six months.

(2) For between meal snacks, nutritional foods instead of energy producing foods are recommended (fresh fruits and vegetables as opposed to candy, cake, soft drinks, etc.)

(3) Teeth should be brushed immediately after each meal.

(4) X-rays should be taken of the teeth whenever indicated.

If the pediatrician can detect some of the poor oral conditions existing in the young patient while he is being examined, the dentist's job will be made easier, and the child, with good dental health, will have a smile to keep.

# STENOSIS OF THE URETHRAL MEATUS

William H. Bennett, M.D.  
William N. Morrison, M.D.  
Ted L. Staton, M.D., *Atlanta*

## ■ Recognition and treatment of this condition is discussed.

**S**TENOSIS, or stricture of the urethral meatus, is one of the most common disorders of the urinary tract. Campbell states that, "one-fifth of all urological disorders are caused by stricture of the terminal urethra." Campbell further states that, "proper and early correction of the meatal stenosis would forestall thousands of episodes of acute pyelonephritis in the young.

Almost every pediatric and urologic text book contains discussions on this subject, yet many adults are seen daily with urological conditions which could have been prevented by early correction of a stenotic urethral meatus.

### Etiology

There are no known embryologic etiologic factors. The condition is seen in both sexes. It may become symptomatic at any age. There are no known racial, social, familial or environmental factors influencing incidences. In our experience only one of identical twins needed meatotomy in the three sets of twins examined.

The effect of circumcision has been considered. Stenosis of the meatus probably occurs in a higher percentage incidence in the uncircumcised, particularly when the phimosis is snug and not corrected until adulthood.

The technique of circumcision performed on newborns at the Georgia Baptist Hospital has been observed. Several techniques are routinely used. We have found no post circumcision trauma or evidence of reaction about the meatus which could lead to scarring and stenosis.

Efforts to correct stenosis at the time of circum-

cision have been unsuccessful because without frequent dilatation of the meatus during the healing period the meatus will reheal to its original or smaller size. Adequate dilatation cannot be accomplished when the penis is swollen from circumcision.

### Incidence

We believe that probably up to 20% of newborns have an abnormally small urethral meatus. It must be emphasized that not all of these are symptomatic early in life. Nearly all individuals with a hypospadias meatus show some degree of stenosis.

Symptoms vary to an extremely wide degree. Many children with an extremely tiny meatus are completely asymptomatic. On rare occasions newborns are found to have marked dilatation of the urethra, bladder, ureters and renal pelvis due to stenosis at the urethral meatus. The symptoms found in these children are those of uremia.

The symptoms usually seen in infants are:

- 1) Straining before and during urination.
- 2) Frequent voiding of small amounts of urine.
- 3) Crying before and during urination.
- 4) Severe diaper rash.
- 5) Ulceration and inflammatory reaction about the meatus (meatitis).
- 6) Colic and food spitting.

Between ages one and six years.

- 1) Frequency of urination.
- 2) Hesitancy and straining on urination.
- 3) Failure to train; usually urgency incontinence.



4) Nocturnal enuresis.

5) Meatitis.

Above six years.

1) Enuresis.

2) Meatitis.

3) Non-specific urethral discharge, prostatitis and chronic urethritis.

4) Dysuria, frequency, urgency and hematuria.

Severe stenosis can cause acute or chronic urinary retention which can in time cause vesico-ureteral reflux and pyelonephritis which will be manifested by fever, chills and fever, and bizarre abdominal or flank pains.

### Physical Findings

Abnormal findings are usually confined to the terminal urethra. The meatus is usually located near the center of the glans, is usually round rather than oval, and may or may not show ulceration or inflammation. Occasionally scab formation and bleeding is seen. There usually is a thin membrane of glistening, whitish tissue extending from the meatus to the frenulum penis. The entire meatus may be surrounded by a ring of scar tissue.

The stream of urine is usually small with a marked projectible force.

A thin mucopurulent urethral secretion may be present. Post voiding stripping of the terminal urethra usually yields a thin secretion which contains a varying number of pus cells. This is especially significant when the urinalysis has been found negative for formed cellular elements.

Condylomata acuminata are occasionally found projecting through the meatus or are found in the terminal urethra when the meatus is incised.

Severe stenosis may cause urinary retention at which time the bladder may be palpable. Suprapubic tenderness occasionally is present. Abdominal or costovertebral tenderness may be present.

Such conditions as congestive prostatitis, verumontanitis, epididymitis and bladder neck obstruction may occasionally be directly blamed on stenosis of the meatus. We have had the questionable experience of having infertility corrected by meatotomy in three instances.

### Treatment

Urethral meatotomy is a simple office procedure in most instances.

Infants are usually done without anesthesia. The glans is simply pressed firmly from side to side for two-three minutes then the meatus is spread laterally and using sharp pointed scissors the whitish line is snipped at six o'clock. The length of the incision is determined by the location of the meatus. Usually

the incision should extend from the meatus to about half the distance to the frenulum. When a shelf is present on the anterior lip of the meatus this should be incised at twelve o'clock.

Other children and adults require local anesthesia. We usually use 1% Procaine, injected with a 25 or smaller gauge needle. The anesthetized area is then clamped with a straight Kelly clamp positioned at six o'clock and extending toward the frenulum. Scissors are then used to incise through the exact center of the clamped tissue. Special meatotomy forceps are available, but they do not have a significant advantage.

Meatotomy is performed in a similar manner on females, however, hospitalization and general anesthesia is preferable. We believe that the majority of females with a stenotic urethral meatus will also have urethral strictures.

Postop bleeding is rarely a problem. When it does occur it can be easily controlled by pressure, cautery or suture.

The enlarged meatus re-epithelializes rapidly, usually healing is complete within a week. The parent or patient is advised to use the nozzle of a small tube of antibacterial eye ointment to spread the cut edges two or three times daily.

The patient is examined one week postoperatively. If the cut edges have adhered, the incision can easily be reopened by forcing a blunt point through the area.

### Electro-cautery

The use of electro-cautery for the incision has been recommended. This has the advantage of better hemostasis and less trouble keeping the cut edges separated, however, this special equipment is not necessary and is not easily available to most of us. Cautery by a styptic agent such as Silver Nitrate can be used with equally good results.

### Complications Rare

Postoperative complications are rare. Some patients will refuse to void for prolonged periods. Catheterization has not been required. Forced fluids and sedation are frequently helpful.

Should symptoms continue after the meatotomy has healed a complete urological survey is indicated. An excretory urogram, urethrogram, cystogram cystometrogram and cystoscopic examination will reveal the presence of other obstructive uropathy.

### Summary

Stenosis of the urethral meatus is very common. It is readily recognized. Meatotomy is accomplished easily. Correction at an early age is recommended.

340 Boulevard, N.E.



# HEREDITARY MUSCULAR ATROPHY

Waldo E. Floyd, Jr., M.D., *Macon*

- *This disease is reviewed from a diagnostic, pathological and corrective surgical viewpoint.*

**H**EREDITARY MUSCULAR ATROPHY is a disease which has been frequently misdiagnosed. The patients are often wrongly advised that they have muscular dystrophy, multiple sclerosis, Friedreich's ataxia, amyotrophic lateral sclerosis, or some other disease of poor prognosis.

It is a hereditary form of progressive muscular atrophy which was first described in 1886 by Charcot and Marie and later in the same year by Tooth. It has been known by various names such as hereditary muscular atrophy of the peroneal type, peroneal muscular atrophy, neural progressive muscular atrophy and Charcot-Marie-Tooth disease. Although the peroneal nerve is frequently involved, there are also other nerves involved, so designating it the "peroneal type" is not altogether correct. It differs from the muscular dystrophies in that the muscle cells themselves are not directly affected but there is a degeneration of the peripheral nerves and the anterior horn cells as in poliomyelitis. The muscle cells show a simple atrophy.

## Hereditary

Some sporadic cases have been recorded but usually the disease is hereditary and a number of pedigrees have been published. The disease may be transmitted as a sex-linked recessive or as a dominant trait. In the sex-linked recessive group only the males are affected, occurring in alternate generations, and transmitted by the female. In the Mendelian dominant group both sexes are equally affected. In our patients, those with the sex-linked recessive trait had early involvement of both the upper and lower extremities, whereas those that were transmitted by the dominant trait had only the involvement of the peroneal nerve without the hand being affected. It has been suggested that exogenous factors may play a part in the causation. An interesting fact, is that the nerves and muscles are the same as those involved most frequently in leprosy.

The onset of symptoms is usually during the second half of the first decade of life but the disease has

been known to occur up to the age of 40. <sup>1</sup>The first symptoms are gradual loss of all dorsiflexion of the foot. The peroneal muscles quickly become affected. The short intrinsic foot muscles are later lost. The triceps surae and posterior tibial are usually slightly if at all affected—they being the deforming factor, a talipes equinovarus develops. The patient has the characteristic foot drop or "steppage" gait.

<sup>2</sup>The hand is last to become affected. The ulnar muscle group supplied by the median nerve is affected the most. <sup>3</sup>The ulnar nerve may be partially affected. This usually occurs several years after the lower extremity has been involved. Fibrillation associated with muscular atrophy is frequently seen. The muscles are not involved individually, but the wasting spreads proximally by a transverse wave. <sup>4</sup>The disease seldom progresses above the elbow or the mid-thigh. When the disease has progressed as far proximally as the mid-thigh, the "inverted champagne bottle limb" is produced. <sup>5</sup>Contractures are rare with this disease. Electromyography reveals absent action potential in the muscles affected. Sensation may be unaffected, but touch, pain and temperature over the periphery of the limbs is usually slightly reduced.

## Normal Life Span

The disease does not shorten life and most patients have lived a normal life span. No known treatment will arrest the course of the disorder. Massage and appropriate exercises will help to maintain the nutrition of muscles and prevent contractures. Foot drop braces will greatly improve the gait. The only permanent improvement is to be gained by surgery.

In the lower extremity, the orthopedic deformity is typically a talipes equinovarus. Peroneal muscle function is usually weak to absent and tibials anterior strength only fair. The strength of the posterior tibial and triceps surae group of muscles is usually good. <sup>6</sup>Surgery consists of some form of foot stabilization such as the Naughton-Dunn, <sup>7</sup>Lambrinudi, <sup>8</sup>or



modified triple arthrodesis of Hoke, whereby the sub-talar, talo-navicular and calcaneo cuboid joints are fused after correcting the bony deformity by wedge resections.<sup>9</sup> The posterior bone block of Campbell was at one time very popular; however,<sup>10</sup> it has not always proved successful since the bone block often absorbs away allowing the foot to return to the equinus position.<sup>11</sup> The posterior tibial tendon can be transferred anteriorly about the medial malleolus to the third metatarsal or third cuneiform as was described by Ober.

<sup>12</sup>If the anterior tibial is somewhat strong, it may be transferred to the middle of the foot and the posterior tibial further over to the os cuboid. We prefer to transfer the posterior tibial tendon through the interosseous membrane by the technique described by Barr. Most tendon transfers are done six weeks after the foot stabilizations. The disease should have reached its quiescent stage before surgery. The Achilles' tendon may have to be lengthened and the plantar fascia stripped. A foot drop brace should be worn for at least six months after the correction of the lower extremity deformities.<sup>13</sup>

### Main Deformity

The main deformity in the hand is a loss of opposition of the thumb due to paralysis of the intrinsic thenar muscle group. The intrinsic muscles supplied by the ulnar nerve may be later affected but this is often minimal and of late occurrence. The loss of opposition of the thumb may be corrected by several means. <sup>14</sup>The sublimis of the ring finger provides the best motor for restoration of opposition of the thumb. The Royle technique consists of utilizing the sublimis tendon of the ring or middle finger, passing it beneath the flexor carpi ulnaris, which acts as a pulley, and then inserting it into the short or long extensor of the thumb. <sup>15</sup>Irwin used this same procedure except he inserted the tendon into the proximal phalanx using the button technique of Cole.<sup>16</sup> Irwin has shown that if the flexor carpi ulnaris is weak, an additional tendon may be brought down to reinforce it. Bunnell used the palmaris longus tendon as a motor and passed it through a static pulley formed about the pisiform bone.<sup>17</sup> Riordan utilized a static type pulley formed by a part of the flexor carpi ulnaris tendon, passing the sublimis tendon through the sheath of the atrophied abductor pollicis brevis and inserted it into the extensor pollicis longus just proximal to the interphalangeal joint to aid in extension of the thumb. Our operations consisted of 20 Opponens transfers, 22 Triple arthrodeses, 18 posterior tibial transfers, and one re-operation to attach the palmaris longus to the distal stump as a substitute motor after the original motor broke around the static pulley.

When both the ulnar and median nerves are severely involved some type of intrinsic transfer may be necessary.<sup>18</sup> Most of the patients gained a functional range of dorsi and plantar flexion and all could oppose the thumb to the ring finger.<sup>19,20</sup>

### Conclusion

In conclusion we feel that the treatment of choice for the burned out stage of this disease is a triple arthrodesis and posterior tibial transfer through the interosseous membrane, preceded by a Steindler stripping and Achilles lengthening if necessary, in the lower extremity. In the hand an Opponens transfer will usually suffice; however, if the ulnar nerve is lost, some form of intrinsic transfer will be necessary. Bone blocks, Panarthrodesis, tenotomy, and other tendon transfers give less satisfactory results.

801 Spring Street

### REFERENCES

1. Barr, J. S.: The Management of Poliomyelitis: The Late Stage, First International Poliomyelitis Conference, Philadelphia, 1949, J. B. Lippincott Co.
2. Brain, W. R.: *Diseases of the Nervous System*, New York, 1951, Oxford University Press.
3. Bunnell, S.: *Surgery of the Hand*, Edition 2, Philadelphia, 1948, J. B. Lippincott Co.
4. Buzzard, E. F., and Greenfield, J. G.: *Pathology of the Nervous System*, 1921, London.
5. Charcot, J. M., and Marie, P.: Sur-une forme particuliere d'atrophie Musculaire progressive souvent familiale, *Rev. de Me'd.* VI 97.
6. Dunn, Naughton: Suggestions Based on Ten Years Experience of Arthrodesis of the Tarsus in the Treatment of Deformities of the Foot, Robert Jones Birthday Volume, London, 1928, Oxford University Press, pp. 395.
7. Eisenbud, A., and Grossman, M.: Peroneal Form of Progressive Muscular Atrophy, *Archives of Neurology and Psychiatry* XVIII. pp. 766, 1927.
8. Herringham, W. F.: Muscular Atrophy of the Peroneal Type Effecting Many Members of a Family, *Brain*, XI. pp. 230, 1888-89.
9. Hoke, Michael: An Operation for Stabilizing Paralytic Feet, *Journal of Orthopedic Surgery* 3:494, 1921.
10. Erwin, C. E., and Eyler, D. L.: Surgical Rehabilitation of the Hand and Forearm and Disabled by Poliomyelitis, *Journal of Bone and Joint Surgery*, 33A:679, 1951.
11. Jacobs, J. E., and Carr, C. L.: Progressive Muscular Atrophy of the Peroneal Type (Charcot-Marie-Tooth Disease). Orthopedic Management and an End Result Study, *Journal of Bone and Joint Surgery*, 32A:27, 1950.
12. Lambrinudi, C.: New Operation on Foot Drop, *British Journal of Surgery*, 15:193, 1927.
13. Ober, Frank R.: Tendon Transplantation in the Lower Extremity, *New England Journal of Medicine*, 209:52, 1933.
14. Peppe, H.: Zur Pathogenesederneurotischen Muskela-trophie. *Ztueschr. F. D. Ges. Neurol., U. Psychiat.* XcII. 324. (1924).
15. Riordan, D. C.: Restoration of Opposition to the Thumb, Hand Course, Tulane University, March, 1957.
16. Royle, N. W.: An Operation for Paralysis of the Intrinsic Muscles of the Thumb, *Journal A.M.A.*, 111:612, 1938.
17. Speed, J. S., and Knight, R. A.: *Campbell's Operative Orthopedics*, Volume 2, 3rd Edition, 1956, The C. V. Mosby Co., St. Louis, Missouri.
18. Symonds, C. T., and Shaw, M. E.: Familial Claw-foot with Absent Tendon Jerks: A (forme furste) of the Charcot-Marie-Tooth Disease. *Brain*, XLIX. 387 (1926).
19. Tooth, H. H.: The Peroneal Type of Progressive Muscular Atrophy, Caimbridge Thesis, 1886, London.

# THE TREATMENT OF FELONS

James E. Anthony, Jr., M.D., *Decatur*

■ *These infections apparently are on the increase and treatment of them generally seems indifferent.*

A FELON is an infection in the closed distal compartment of the digits of the hand. Despite the widespread and frequent use of antibiotics, this is still a common infection. It usually follows a trivial puncture wound which often is barely noticed. The purpose of this paper is to point out that early incision and drainage is necessary and curative.

## Infection Well Incubated

Following a puncture wound of this distal closed space, an infection may be introduced which can be well incubated in this lush area. With the skin attached to the deeper tissues by dense fibrous bands, there is little room for expansion by edema. Consequently, the expanding infection produces pressure on the digital nerves with exquisite pain and tenderness. Usually the patient has been unable to sleep the night before he consults his physician.

On physical examination, the finger tip is bulbous, diffusely swollen, with the swelling more or less demarcated at the distal crease. It is extremely tender, red and hot, and throbs incessantly.

Previously, teaching has been that the patient should be hospitalized and under general anesthesia with a tourniquet; mid-lateral incisions were to be made and drainage of this compartment instituted. Because hospitalization with general anesthesia was recommended, there was a tendency to wait until the physician was sure that this was a felon. Delay in drainage almost invariably follows this approach.

For this reason, felons should be drained immediately in the office under block anesthesia without loss of time. Digital nerves can be readily blocked without complication by using 2-3 ccs. of 1% xylocaine without adrenalin and tourniquet. A mid-lateral incision is made, but stopped somewhat short of the distal crease. One must be careful not to enter the flexor tendon sheath at this joint. A smaller counter incision may be made on the opposite side and a knife or hemostat passed through, and a small rubber through and through drain may be left in place. If one finds pus in this closed space, the incision and drainage has been delayed. The important factor is not to drain out the pus, but to release pressure, and because this point has not been emphasized enough, too many felons are reaching the surgeon at the pus forming stage. Most felons should not have pus when they are drained.

## Little Place for Antibiotics

Antibiotics have little place in the treatment of terminal space infections. They do not cure the infection, but serve merely to mask it and to give the physician a sense of false security. Invariably, surgery will be required.

It is far better to incise and drain the terminal compartment when in doubt than to wait for extensive damage to occur. The incision of such drainage heals very kindly with minimal scarring, but the damage from delayed incision can result in a chronic osteomyelitis of the distal phalanx with marked deformity and malfunction.



# For Your MAG 1965 Annual Session Hotel & Motel Reservations

## APPLICATION FOR HOTEL AND MOTEL ACCOMMODATIONS

Medical Association of Georgia 111th Annual Session

May 2-4, 1965 — Augusta, Georgia

A HOUSING BUREAU has been established for your convenience in making hotel and motel reservations at Augusta for the 1965 Annual Session of the Medical Association of Georgia. Comparable room rates and accommodation information are listed. *Use the Reservation Form below.* Please specify your first, second and third choice hotel or motel. All requests for reservations should give: (1) anticipated date and hour of arrival; (2) date and approximate hour of departure; (3) names and addresses of all persons who will occupy the accommodations. All reservations must be cleared through the Housing Bureau. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible to secure the accommodations you request. All reservations will be confirmed.

**Augusta Town House:** Broad at Albion St. (722-5541).

**Single \$7 up, double \$8.50 up, twin beds \$9.50 up.** 100% Air Conditioned, Swimming Pool, TV-Radio, Free inside parking, barber and beauty shop, two cocktail lounges, two restaurants, newstand, Gift Shop, package shop — Heart of Augusta — 300 Rooms.

**Downtowner Motor Inn:** Reynolds at 8th St. (722-5361).

**Single \$8 up, double \$10.50 up, twin beds \$12.00 up.** 100% Air Conditioned, Radio — TV, Free parking. Swimming pool, Cocktail Lounge, Restaurant — 100 rooms.

**Warrick — Quality Motel:** Broad at 4th St. (722-0212).

**Single \$8 up, doubles \$10, twin beds \$12.** Air Conditioned — TV, Free Parking, Free Continental Breakfast. Cocktail Lounge — 69 Rooms.

**University Motel:** 1410 Gwinett St. (724-8204). **Single \$7**

**up, double \$9 up, twin beds \$10 up.** Air Conditioned.

— TV, Free parking, Restaurant near-by, Adjacent Talmadge Memorial and University Hospitals — 68 Rooms.

**Medical Center Motel:** 1480 Gwinett St. (722-4828). **Single**

**\$7 up, double \$9 up, twin beds \$10 up.** Air Conditioned — TV, Free Parking, Restaurant next door, Adjacent Talmadge Memorial and University Hospitals — 45 Rooms.

**Howard Johnson Motor Lodge:** 1238 Gordon Highway.

(724-9613). **Single \$9 up, double \$12 up, twin beds \$13.** Air Conditioned — TV, Swimming Pool, Free parking, Restaurant and Cocktail Lounge — 61 Rooms.

**Holiday Inn:** 1602 Gordon Highway. (798-2782). **Single**

**\$7 up, double \$11 up, twin beds \$11 up.** Air Conditioned — TV, Swimming Pool, Restaurant, Cocktail Lounge, Free Parking — 110 Rooms.

*Confirmation of your request for accommodations will be in accordance with preference indicated, if possible; if not, best substitutes will be made. Deposit of one day's room rent will be required with each request for accommodations.*

Cut out and send to:

Please Type or Print

HOUSING BUREAU, MEDICAL ASSOCIATION OF GEORGIA

Augusta Town House, Augusta, Georgia — Attn: Otis Phillips, Vice-President — Sales

Please reserve the following accommodations for the 1965 Annual Session of the

Medical Association of Georgia.

### Hotel or Motel Preference

1st Choice \_\_\_\_\_ ☐ Double Room at \$ \_\_\_\_\_ to \$ \_\_\_\_\_

2nd Choice \_\_\_\_\_ ☐ Double Room at \$ \_\_\_\_\_ to \$ \_\_\_\_\_

3rd Choice \_\_\_\_\_ ☐ Twin Bedroom at \$ \_\_\_\_\_ to \$ \_\_\_\_\_

☐ Other type \_\_\_\_\_

Arrival Date \_\_\_\_\_ Hour \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

Departure Date \_\_\_\_\_ Hour \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Include all names of all persons for whom you are requesting reservations and who will occupy the room(s):

Name of Occupant(s)

Address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Individual Requesting Reservations

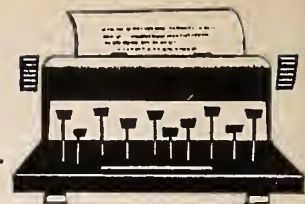
Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

*If hotels or motels of your choice are unable to accept your reservations, the Housing Bureau will make reservations to fit your specifications elsewhere.*



## In Appreciation

THE COUNCIL of the Medical Association of Georgia has asked the Chairman of the Association National Legislative Committee to thank the many physicians over the state for their efforts in behalf of the public and the profession in preserving our principles as they affect the critical issue of health care of the aged.

Hundreds of physicians of Georgia effectively participated in defending medical freedom during the recent 88th Congress. They devoted a great amount of time and effort in what was certainly a tremendous demonstration of teamwork. I wish to express to you my appreciation and, on behalf of the Medical Association of Georgia, our sincere thanks for your contribution in this effort.

### Continued Efforts

We must continue our efforts to maintain the free practice of medicine as we know it in this great land. We have no choice but to stand firm in our effort to prevent the standards of health care in this country from being undermined by radical departure from the unique American Way which has accomplished so much for mankind.

We as physicians indorse and support health care for all of the aged who need help, as our Kerr-Mills involvement shows to all. We support the expansion

of voluntary health insurance and prepayment plans. We are unalterably opposed, however, to a program of government financed and government managed health care -Medicare- which would give less care and poorer care at greater cost. Let us stand for medical care for everyone regardless of ability to pay for it, but not a Medicare program offering only limited care to all regardless of need, with governmental control intervening between the patient and his physician.

### The Gathering Clouds

The storm clouds gather in the new 89th Congress. It is said the "Medicare" issue will be settled during the first six months of 1965. To those to whom we owe a debt of gratitude for loyal and devoted efforts, we turn again, asking for a redoubling of efforts and a redirection of activity. Stronger action is needed now to safeguard for the people a progressive and dynamic system of medicine without equal anywhere on earth. Express our gratitude and deep appreciation to our allies for the assistance they gave in this effort, and alert them to renew their efforts to tell the public the facts about the Medicare Tax.

Let us not abandon the American People, who will be the real losers should we fail in our renewed efforts to stop the trend toward socialized medicine.

*J. Frank Walker, M.D.*

## The New 1965 AMA Legislative Proposal On Health Care of the Aged

HERE IS THE AMA's statement outlining a sound, sensible and workable health care program which will accomplish far more than would be possible under the so-called Medicare tax program, with none of the attendant evils of unpredictable expense, invasion of medical practice by the federal bureaucracy or disruption of the private health insurance industry by the government.

The American Medical Association has proposed action by Congress to assure comprehensive health care for the aged, while easing and accelerating procedures under which applicants would qualify for benefits.

This plan is designed to assure that every person over 65 whose income is insufficient to pay for coverage will receive help from public funds. The



AMA pointed out that this program would provide far more to our elderly citizens than is proposed in the administration's "medicare" tax program.

Aid would consist of comprehensive health care benefits rather than being limited to hospital and nursing home care, representing only a fraction of the cost of sickness. Benefits for eligible recipients would include not only payment of hospital and nursing home charges, but also payment of medical, surgical, and drug costs.

Eligibility for benefits would be determined quickly and readily without the necessity for a welfare department type of investigation. It would be determined on the basis of the applicant's simple income statement. Under this method, an individual would qualify for help before illness strikes.

This program would operate through the established insurance system by utilizing the private

carriers for its administration. It would utilize, not replace, the existing insurance and prepayment plans on which many millions of younger Americans depend for their protection from illness costs.

The proposed expansion of the federal-state program to finance health care for the aged was outlined by Dr. Donovan F. Ward, president of the AMA. He noted that all the modifications are in keeping with established AMA policies. He said:

"We are maintaining our basic positions that: (1) all those over 65 who need help in paying for health care should receive it; (2) in providing this help the relations between the states and the federal government should be preserved with maximum responsibility and authority delegated to the state rather than to a centralized Washington authority; and (3) voluntary health insurance and prepayment principles should be utilized whenever possible.

## The Tune is the Same

THE WORDS are slightly different—but the tune is the same as before.

The new health care for the aged bill, introduced by its perennial sponsors (Rep. King and Sen. Anderson) differs slightly from their bankrupt versions of prior years. In the main, however, it is a warmed over treatment of the same bill they have been pushing since 1961.

The 1965 rendition of the King-Anderson "medicare-tax" bill would provide for only 60 days hospitalization whereas previous versions of this proposal extended 90 days hospital care per year. Nursing home care has been reduced from 180 days as proposed in the 1963-64 King-Anderson bill down to 60 days in the current bill.

### Small Consequence

One should bear in mind that the level of benefits payable under the program is of small, if any, consequence to its proponents. What is important to them is that the principle of government financed (and control of) health care without regard to need be established. Once this is done the benefits and scope of coverage can be expanded every election year that rolls around until the level of benefits thought appropriate by these bureaucratic self-appointed "overlords" is obtained.

Home health services and outpatient diagnostic services in this bill remain the same as in last year's model. Financing, however, would be done by a separate Hospital Insurance Trust Fund established

within the Treasury Department. The program would be administered by the Department of Health, Education and Welfare.

The base on which the increase in Social Security taxes would be levied would be \$5600 compared to \$4800 presently. Employers and employees would each begin paying 4.25% on the first \$5600 of income starting in 1966. This would increase periodically until 1971 at which time employers and employees would pay a combined total Social Security tax of 10.4% of income.

The self employed rate would increase from 6.4% in 1966 to 7.8% in 1971. The self-employed rate is significant because this bill would also forcibly extend Social Security coverage to physicians for the first time.

### Domination

Even a casual perusal of the King-Anderson proposal will reveal its potential for the ultimate and complete domination of the medical profession in this country. This is not new. The potential for doing great harm to what all will concede is the finest system of health care in the world has always been present in the Social Security medicine schemes of the past. As the saying goes "we have our work cut out for us."

This next month will be critical. We can win this fight to preserve the free status of the medical profession if we really want to. Or, we can lose it through inaction and by assuming that legislative "street fighting" (even for a good cause) is really somebody else's job.

## What Did the PAC Movement Contribute In '64 Elections? Plenty, Say Candidates

*The election of 1964 is now history.*

*The conservatives and moderates of both parties took a beating, a circumstance that has evoked several million words of commentary, explanation, and analysis by now.*

*The defeat cannot be minimized. Nor can it be sloughed off as simply one more demonstration of how the ball bounces.*

But having agreed that the defeat was—and is—a matter for deep concern; having stated that for every winner in politics there is at least one loser; and having voiced the conviction that 1965 will not usher in the era of the sunshine soldier, more important and immediate comments are in order.

To begin at the beginning:

Many of medicine's friends in the 89th Congress might not be there had it not been for the physicians and physicians' wives of the United States.

Who says so? Winner after winner—in both parties.

More of medicine's friends would be in the 89th Congress had other groups produced comparable candidate support.

Who says so? Loser after loser—in both parties.

Dozens of good candidates lost by the skin of their teeth and should win next time out. Dozens of medicine's opponents won by the skin of their teeth and should lose next time out.

The two-party system continues to operate and the

orderly processes of government will continue as they have in the past.

As for the PAC movement, there is this to remember:

We swam with strength, skill, and determination against a ten-knot current. We must now demonstrate the endurance to keep on swimming until the tide turns.

Were all the dollars spent, all the hard work done, sacrifices of no consequence? Did medical political action accomplish anything? Or might we be just as well off if we'd stayed in bed?

We at AMPAC have asked these questions candidly, of every professional politician we encountered, since November 4th.

We invariably get the same answers. The effort was *not* in vain; the dollars were *not* wasted; medical political action did indeed accomplish a worthwhile result. And if we'd stayed in bed, things would be a whale of a lot worse.

Millions of words—spoken and written—have been expended already in summaries and analyses. But these are explanations after the fact. They are moot. They are of more interest to those who interpret history than to those who make it.

Let us remember, therefore, that the confetti has long ago been swept up; that the bunting has been stored away until next time; and that the celebrations of the winners and the wakes of the losers are now old memories.

The time has come to begin work for tomorrow.

Donald E. Wood, M.D.,  
Chairman, Board of Directors, AMPAC

Reprinted from *Political Stethoscope*, published monthly by American Medical Action Committee, 520 N. Michigan Ave., Chicago 11, Illinois.

### POST GRADUATE COURSE IN RADIOISOTOPE SCANNING PLANNED AT EMORY UNIVERSITY

The Department of Radiology, Division of Nuclear Medicine, of Emory University School of Medicine will conduct a Post Graduate Course in "RADIOISOTOPE SCANNING IN CLINICAL PRACTICE," April 23-24, 1965, at the Grady Memorial Hospital, Atlanta. The guest faculty will include Doctors David Charkis, Wil-

liam Eyler, Phillip Johnson, James Quinn, Bruce Sodee, Henry Wagner, Jr. and Mr. Craig Harris.

Further information may be obtained from H. S. Weems, M.D., Department of Radiology, Emory University School of Medicine, Atlanta, Georgia, 30322.



# PRESIDENT'S LETTER

---



## ST. VALENTINE'S DAY

**I**T'S FEBRUARY NOW—we have all settled down after Christmas and the New Year. Gone are the stockings that hung by the fireplace, the Christmas tree has been burned and our New Year's resolutions have faded one by one. We are back, by now, in the old routine, day in and day out.

### The Best Laid Plans

On New Year's Day last year we firmly resolved to take a little more time off to get to know our family better. We planned to do a great many things together. But somehow, in the hurly-burly of life's activities, things never worked out that way. If a family activity was planned, it acted like a magnet for an emergency; and pretty soon the wife had a church meeting or a sewing bee on your afternoon of so-called leisure, but most likely she had to take the children to practice football, basketball, baseball, little league, music or dancing, to say nothing of cheer-leading and many of the other things that a wife and children have to do.

Unfortunately for us, we cannot plan our work as accurately as the coach or the teachers or even the preachers. We doctors, God help us, come home at times to an empty house on our afternoons off, or to a home in great turmoil. There are certain things that children have to do immediately after school in the afternoon or during the summer vacation, and when these things are in progress, the old man doesn't count for too much—and maybe that is as it should be.

I've fussed about these things over the years and oftentimes have been plagued with the idea that about the only thing a man was good for around the house was to bring in a few shekels to further that delightful contest between wife and children as to which one could get rid of them first.

### A Change in Thinking

As I've grown older, however, there has come a little change in my thinking. Two of my children are now married and have families of their own. I see the fruition of some of the hard work done by my wife, the preacher, the coaches, teachers, etc. This was accomplished while neglecting me

during the days of long ago. Two other children are now grown, and I see in them some of the niceties and refinements that she taught them, while over-looking—so I thought—her ever-loving husband.

And this brings me to my subject. It's St. Valentine's Day this month—a time for a little sentimental expression or gift to the love of our life. We doctors over the state, one and all, should not only this month, but many times during the year, sit down in the cool of the evening for a little while and ask our life's companion to recount the joys and sorrows of the day. I will guarantee that she will love this more than candy.

Our thoughts are so monopolized by the chronics in the office, our problems in the hospital, sick patients and all those things, that we never think about our wives and their dull committee meetings at various places, the paper sales, the frustrations that arise in hauling groups, car trouble, parking tickets, giving out of gasoline, losing their keys and all those things. We never think too much about our own children getting sick, or even our wives. They usually get an aspirin or some handy sample, but our wives worry.

### A Sympathetic Ear

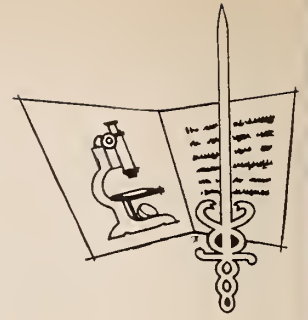
Again, she would dearly love to have an attentive and sympathetic ear, especially after darkness has settled, the moon is up and the chores are finished. As she recounts her recent joys and frustrations, she would like a look of intense interest. Do not let your thoughts wander back to a sick patient in the hospital. Put your newspaper or medical journal out of reach while she is talking and do not glance at it from time to time. Lend thine ear to her for a little while and you will be far wiser and happier—and so will she.

*The fox, when he could not reach the grapes, said they were not ripe. The man, who is not thoughtful of his wife, says she neglects him.*

A stylized, cursive signature of J. G. McDaniel.

J. G. McDaniel, M.D.

President, Medical Association of Georgia



## BETTER TO LIVE IN SOUTH AFRICA OR SOUTH GEORGIA ? ? ?

Leslie C. Buchanan, M.D., *Decatur*

**N**O NOVEL AFFORDS more fascinating reading than does the ever-mounting pile of data regarding the environmental factors which have been shown, or strongly suspected, to have a causal relationship to the different forms of cancer.

### Epidemiologic Aspects

Some customs such as betel chewing widely practiced in India, Burma, Ceylon, Pakistan and Guam; and nass\* chewing in the Central Asian Republics of the U.S.S.R., are associated with a comparatively high incidence of oropharyngeal cancer. The now famous Bur Kitt sarcoma is virtually completely confined to certain tropical geographic areas where altitude, temperature, rainfall, etc., are constant within narrow limits. American women have approximately seven times the incidence of breast cancer as do Japanese women and breast cancer is more common in unmarried than in married women. A significant incidence of primary pulmonary cancer in rural Georgia dairy cows which neither smoke cigarettes nor breathe the air of industrialized urban communities has been noted. All these are but a few examples of the environment—epidemiologic aspects of cancer in focus today. Most of these interesting facets are already under study and evaluation by the scientific method. An intensive formal study of factors possibly related to the relatively low incidence of breast and uterine cancer among women in Japan is to be conducted in 1965. [This study is to be subsidized by the American Cancer Society and carried out with the cooperation of Japanese medical leaders.]

Today cancer of the colon and rectum in the United States is the Number One internal cancer occurring in both men and women. Colorectal cancer is the only internal malignancy in which the in-

cidence is the same in both sexes. During 1965 there will be 76,000 new cases and 46,000 deaths from colorectal cancer. In a recent study of 32,177 symptom-free persons, three of every 1,000 were found to have cancer of the colon or rectum.

There is a group of cancers which appears to be related to etiological factors in our environment which have not yet been identified. Cancer of the stomach has been showing a remarkably steady decline in the United States for the past 30 years for no known reason. At the same time, cancer of the stomach has been continuing to increase in Yugoslavia, Mexico, in India, and particularly in Japan where it is the Number One cancer. [It also continues to be a major cancer in the Soviet Union and countries behind the Iron Curtain as well as in Iceland.] The Japanese who live in the United States do not have this high incidence. In the same countries that have a high incidence of cancer of the stomach, there is low incidence of cancer of the rectum and colon. Colorectal cancer incidence is low in Mexico, Latin America, India and in Japan.

### Increases In Urban Communities

Epidemiological studies just completed by Dr. William Haenszel of the National Cancer Institute show a definite increase in cancer of the colon in people in urban communities as compared with those in rural communities, and an appreciably higher rate in people in the northern part of the United States as compared with those in the southern states. [These findings remain consistent in migrants from the northern states to the southern states, and vice-versa, as well as in migrants going to and from rural and urban centers.] One might then facetiously

---

\*Composed of tobacco, lime, ash and butter.



assume that, as regards cancer of the colon or rectum, the ideal situation is to be born of Caucasian parents on a farm in south Georgia. The validation and true significance of all these factors must await conclusion of the many epidemiological studies in progress. In the meantime, what can be done about the Number One internal cancer expected to kill 46,000 people this year???

At least 75% of all cancers of the entire rectum and colon are anatomically within reach of the standard 25 cm. sigmoidoscope. Only 13% of the

colorectal carcinoma detected in thousands of examinations were in reach of the examining finger, even with the patient straining.

Whether we practice in south Georgia or northern Tanganyika, we **MUST** make proctosigmoidoscopy a *routine* part of the examination of asymptomatic as well as symptomatic patients.

374 West Ponce de Leon Avenue

Approved by the Professional Education Committee, Georgia Division, ACS.

## CONTROLS MUST BE INFORMED — LIKE PATIENTS

It is worth noting that the law . . . (now) requires the investigator of new drugs to inform "any persons used as controls" that "drugs are being used for investigational purposes." The term "drugs" is confusing because it could refer to the new drug itself or to placebos or stranded drugs given to the controls. Disclosure of full information to the controls may be highly detrimental to the drug study. Such disclosure introduces a highly undesirable psychological element, in-

consistent with the statutory requirement for adequate and well controlled studies for proving the effectiveness of a new drug. The conclusion is inescapable. The federal regulations and, if need be, the law, should be modified, so as not to interfere with medical practice and the orderly investigation of new drugs. — Francis Boyer, Chairman of the Board, Smith Kline and French Laboratories, in *New England Journal of Medicine*, 270: 15, (April 9), 1964.

## 1965 CALENDAR OF MEETINGS

### State

- March 2-3, 1965—"Concepts of Fetal and Maternal Welfare," sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.
- March 8-9, 1965—Diabetes Seminar, sponsored by the Georgia Department of Public Health, Georgia Academy of General Practice, Diabetes Association of Atlanta, Georgia Diabetes Association, Atlanta Americana Motor Hotel, Atlanta.
- March 31-April 2, 1965—"Problems in Gastroenterology," sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.
- April 1-3, 1965—Annual Meeting of the Georgia Society of Ophthalmology and Otolaryngology, Callaway Gardens, Pine Mountain, Ga.
- April 3-4, 1965—Joint Meeting of the Atlanta Society of Pathologists, and the Gulf Region, College of American Pathologists, Academy of Medicine, Atlanta.
- April 8, 1965—Symposium on Cardiovascular Diseases, co-sponsored by the Third District Medical Society and Lederle Laboratories, Ralston Motor Hotel, Columbus.
- April 23-24, 1965—Southeastern Section of the Association for Research in Ophthalmology, Emory University, Atlanta.
- April 23-24, 1965—Postgraduate Course in "Radioisotope Scanning in Clinical Practice," sponsored by the Department of Radiology, Division of Nuclear Medicine, of Emory University School of Medicine, Grady Memorial Hospital, Atlanta.
- May 2-4, 1965—111th Annual Session of the Medical Association of Georgia, Augusta.

### Regional

- February 25-March 2, 1965—American Dermatological Association, Boca Raton Hotel, Boca Raton, Fla.
- February 26-28, 1965—Virginia Pediatric Society, The Greenbrier Hotel, White Sulphur Springs, W. Va.

- March 4-5, 1965—Obstetrics and Gynecology Seminar sponsored by the Division of Postgraduate Education of the University of Florida College of Medicine, Gainesville, Fla.
- March 8-9, 1965—Seminar in E.N.T., sponsored by the Medical College of South Carolina, Division of Postgraduate Education, and the Department of Ear, Nose and Throat, Medical College Hospital, Charleston, South Carolina.
- March 8-11, 1965—New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La.
- March 22-24, 1965—Dallas Southern Clinical Society, Statler-Hilton Hotel, Dallas.
- March 23-26, 1965—National Society for Prevention of Blindness, Rice Hotel, Houston.
- March 25-27, 1965—Mid-Central States Orthopaedic Society, Velda Rose Motel, Hot Springs, Ark.
- March 26-27, 1965—National Conference on Rural Health (18th) Americana Hotel, Miami Beach.
- March 29-31, 1965—American Association for Thoracic Surgery, Roosevelt Hotel, New Orleans.
- April 18-21—18th Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Va.
- April 26-29—American Academy of Pediatrics, Americana Hotel, Bal Harbour, Fla.

### National

- April 4-8—13th Annual Clinical Meeting of the American College of Obstetrics and Gynecology, San Francisco, Calif.
- May 24-28—A Five Day Refresher Course in Pediatrics sponsored by the Children's Hospital of Philadelphia and the Department of Pediatrics, School of Medicine, University of Pennsylvania, Philadelphia, Pa.
- June 20-24, 1965—American Medical Association, Americana Hotel, New York City.



THE ELECTROCARDIOGRAM OF  
THE NORMAL NEWBORN INFANT

Nanette Kass Wenger, M.D., Atlanta

THE MAJOR ELECTROCARDIOGRAPHIC differences between the newborn infant and the adult are attributable to the normal right ventricular preponderance of the infant as compared with the normal left ventricular preponderance of the adult.

*Technique:* A good quality infant electrocardiographic record is most easily obtained with a direct writing recorder; however, a photographic record at double paper speed yields the most accurate information. The standard extremity leads and precordial

leads V3R, V1, V2, V4 and V6 usually suffice. Accurate precordial lead recording requires a small chest electrode (1/2 inch diameter) and the careful localized application of electrode paste for each lead position; smeared excessive electrode paste may produce a single pattern across the chest.

*Heart Rate:* The average heart rate may increase slightly during the first several weeks of life. Furman reports a mean of 140/min. in one week, one and 155/min. in the subsequent seven weeks.

*Rhythm:* Sinus arrhythmia is uncommon with the rapid heart rate of the newborn. Ectopic beats, even in series, are far less unusual in the newborn infant than in the older child. Nadas states that in the absence of organic heart disease, the ectopic beats usually disappear without therapy within the first ten days of life.

*P Wave:* P wave axis and amplitude do not vary significantly during infancy. Burch reports the greatest P wave amplitude (1.4—1.7 mm. average) in Leads V1 and V2; Gross describes it in Lead II. The P wave is characteristically inverted in Leads V1 and V2 and upright in Leads V5 and V6.

*PR and QT Interval:* The PR and QT intervals do not vary appreciably with age or heart rate during the newborn period.

*QRS Complex:* The QRS duration generally increases with increasing age; however, Zeigler reports a QRS duration slightly greater at birth than in the one week - one month period, possibly related to the heart rate.

The mean QRS vector of the normal newborn is directed to the right and anteriorly. Fifty per cent of infants in Furman's study had a QRS axis of greater than 105° in the first week of life; this occurred in only 10% after four weeks of age. No axis less than 73° was recorded prior to week four; subsequently the lower limit was 11°.

The anatomic and physiologic right ventricular preponderance explains the dominant R wave in

NORMAL VALUES\*

		0-24 hrs.	1 day - 1 wk.	1 wk. - 1 mo.
Heart Rate (per min.)	av.	125	138	162
	min.	88	100	125
	max.	166	188	188
PR Interval (sec.)	av.	.099	.095	.095
	min.	.08	.08	.08
	max.	.12	.12	.12
P Wave Duration (sec.)	av.	.051	.0485	.048
	min.	.040	.036	.040
	max.	.064	.064	.060
QRS Duration (sec.)	av.	.065	.056	.055
	min.	.04	.04	.04
	max.	.10	.08	.07
QT Interval (sec.)	av.	.294	.266	.238
	min.	.240	.220	.200
	max.	.360	.360	.280
T Wave Duration (sec.)	av.	.143	.146	.117
	min.	.09	.10	.09
	max.	.20	.20	.16
P Wave Axis (degrees)	av.	60	58	55
	min.	-39	0	0
	max.	90	90	120
QRS Axis (degrees)	av.	137	128	105
	min.	75	75	-5
	max.	190	190	180
T Wave Axis (degrees)	av.	77	34	41
	min.	10	-30	-10
	max.	180	110	130
Ventricular Gradient (degrees)	av.	125	111	84
	min.	75	70	5
	max.	185	165	125

\*Adapted from Zeigler, R. F. *Electrocardiographic Studies in Normal Infants and Children*. Charles C. Thomas, 1951.



the right precordial leads and dominant S wave in the left precordial leads, a reversal of the usual adult pattern. The R wave in Lead V1 is larger than that in V6, with an R:S ratio greater than one recorded in all the chest leads. The R wave is small and S wave large in Lead I, and a tall R wave is present in Lead AVR.

During week three, diminution of right ventricular preponderance begins.

Q waves are common in Leads II, III and AVF and are rare in the right precordial leads; the incidence of left precordial lead Q waves increases after the first week of life.

**RS-T Segment:** RS-T segment displacement from the isoelectric line is not unusual in infancy and is observed primarily in the extremity leads.

**T Wave:** There is marked T wave variability during the first three days of life, with low voltage T waves generally encountered for the first two weeks of life.

Zeigler describes an upright T wave in Lead V1 and an inverted T wave in Lead V6 as typical for the first day of life. The T wave pattern undergoes a

rapid reversal and is invariably inverted in Lead V1 after 60-96 hours; it is always upright in Lead V6 by the end of week one.

**QRS-T Angle:** The marked variation of the T vector contrasts with the relative stability of the QRS vector during the newborn period. However, the QRS-T angle generally remains less than 40° in all planes, as confirmed by vectorcardiographic studies.

Electrocardiographic clues to the diagnosis of cardiac disease in the newborn infant include:

- 1) A heart rate greater than 250-300/min., whereby arrhythmia may produce congestive heart failure;
- 2) Excessive right ventricular preponderance or absence of the normal right ventricular preponderance;
- 3) Marked ST-T changes of myocardial injury; and
- 4) Failure of normal T wave evolution.

69 Butler Street, S.E.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

## CARDIOVASCULAR DISEASE SYMPOSIUM TO BE HELD AT COLUMBUS IN APRIL

A symposium on cardiovascular diseases will be held on April 8, 1965, at the Ralston Motor Hotel, Columbus, Georgia. It is co-sponsored by the Third District Medical Society and Lederle Laboratories.

### — PROGRAM —

1. CORONARY ARTERIOGRAPHY —  
William Sheldon, M.D., The Cleveland Clinic Foundation
2. CARDIAC PROBLEMS OF PREGNANCY —  
James Metcalf, M.D., Associate Professor of Medicine, University of Oregon School of Medicine
3. EVALUATION & CURRENT TREATMENT OF CEREBROVASCULAR OCCLUSIVE DISEASE—  
Clark H. Millikan, M.D., Head, Section of Neurology, Mayo Clinic
4. SURGICAL TREATMENT OF ACQUIRED DISEASES OF THE AORTA & PERIPHERAL ARTERIES —  
Michael E. DeBakey, M.D., Professor and Chairman, Department of Surgery, Baylor University College of Medicine
5. CARDIAC FAILURE IN INFANCY—RECOGNITION AND MANAGEMENT —  
Mary Allen Engle, M.D., Director, Pediatric Cardiology, New York Hospital, Cornell University

6. PANEL — ALL VISITING PHYSICIANS  
MODERATOR: J. Willis Hurst, M.D., Chairman  
Department of Medicine  
Emory University School of Medicine

A COMPLIMENTARY LUNCHEON AND COCKTAIL PARTY (Courtesy of Lederle) will be held for the physicians and their wives. Other entertainment is also being planned for the ladies.

Physicians living in the following counties will receive invitations:

Ben Hill	Harris	Peach	Sumter
Chattahoochee	Houston	Pulaski	Taylor
Clay	Lee	Quitman	Terrell
Crisp	Macon	Randolph	Turner
Dodge	Marion	Schley	Webster
Dooley	Muscogee	Stewart	Wilcox

If you live elsewhere and would like to attend this program, kindly contact—

Simone Brocato, M.D.  
Physicians Building  
Columbus, Georgia

and a written invitation will be sent for you and your lady.



## SUMMARY OF RECENT MAG COUNCIL AND EXECUTIVE COMMITTEE ACTIONS

(The full minutes from which these summaries have been abstracted are available to any MAG member upon request to the Journal.)

### Executive Committee/December 12, 1964

Treasurer's Report: Dr. Atwater to ask Council for a \$962.60 for overage in office supplies and committee functions for 1964. Report was approved with request to be made to Council.

Budget report to be presented to Council: Discussion of disbandment of Weekly Health Column Subcommittee was discussed; explanation being a lack of interest on the part of Georgia newspapers.

Voted to ask MAG President to appoint a committee of three to serve as ad hoc committee on quackery.

Letters received from the President of the Georgia Dental Association and the Georgia Association of Pathologists concerning a project on oral cytology which the Dental Health Branch of the Department of Public Health would like to see initiated. Executive Committee voted to approve the project in principle.

Legislative Report received for information: (1) AMA Legislative Meeting, December 13, Chicago; (2) Keyman Meeting, December 16, Atlanta; (3) MAG County Medical Society Leadership Meeting with AMA President, January 17, 1965, Atlanta.

Voted to appoint John N. McClure, M.D., Atlanta, as new Annual Session Scientific Exhibits Chairman to replace Edgar Grady, M.D., who has resigned.

Headquarters Office Report: Resignation of Mrs. Martha Henderson, Secretary, January, 1965; and the approval of the leasing of a Xerox machine for office use.

Approval of Annual Session dates for 1967: Annual Session dates to be April 30, May 1, and May 2, 1967.

Appointment with Governor Sanders to discuss implementation of MAA portion of the Kerr-Mills Law was held December 16, 1964.

Approved: Recommendation for revision of complete fee schedule for State Medicare Review Board.

Approved: Recommendation from Napier Burson, M.D., Atlanta, MAG representative to the AMA Areawide Planning Meeting, Miami, that the five large county medical societies in Georgia meet to formulate plans and to hear suggestions made at the AMA meeting. It was suggested that other societies be asked to send representatives also.

Report received: Dr. Alexander reported on the recent meeting of the Emory University Medical Alumni Council.

### Council Meeting/December 12-13, 1965

Report received: MAG Legal Counsel, Mr. Frank Shackelford, commented on the regulations regarding release of hospital medical records information to other legitimate parties in addition to the hospital and physician—that a legislative statute, should one be passed, would make information available only in certain instances, and would, therefore, protect the hospital and physician.

Report on 1965 Proposed Budget: (1) Deletion of Weekly Health Column due to lack of interest on part of Georgia newspapers, and certificate of commendation for the chairman of the committee;

(2) Retirement Plan Contribution and Taxes appropriation was deferred until the March Council meeting, at which time a more accurate figure for determination of these amounts will be available.

(3) Voted to appropriate \$200.00 for the Industrial Health Subcommittee, but this action was later rescinded because above amount was included in Occupational Health Board Chairman's request of \$300.00.

(4) Voted that it should not be the policy to give automatic across-the-board raises hereafter based entirely on cost-of-living.

Council then voted to approve the 1965 budget with the changes as mentioned.

Voted to ask Dr. Mauldin to represent MAG at the AMA Kerr-Mills Conference, January 9-10, 1965.

Death of Dr. Mercer: Council was informed while in session of Dr. Mercer's death in an automobile accident. A minute of silent tribute was observed and a telegram from the Association sent to Mrs. Mercer. The telegram was worded as follows:

"The Council of the Medical Association of Georgia now in session is deeply shocked and grieved over the news

of Joe's untimely passing. We are sure he was a wonderful husband and father and was one of our most valuable members. The medical profession has been enriched because he was one of us. Please accept our deepest sympathy."

Received for information: Reports of Vice Councilors on contacts made to MAG members who are not AMA members.

### Legislative Report:

(1) *1964 Medicare Campaign*: It was suggested that an editorial by Dr. Frank Walker for the next issue of *JMAG* to thank all who participated in this campaign would be appropriate.

(2) *AMA Legislative Meeting, December 13, Chicago*: Drs. Mauldin, Brown, Walker and Mr. Moffett will attend this meeting to bring back whatever information AMA has to impart for future strategy.

(3) *MAG Keyman Meeting, December 16, 1964*: This meeting will be held next week to inform the MAG Keymen about the AMA meeting on December 13, and to make plans for the future.

(4) *MAG County Medical Society Leadership Meeting with AMA President, January 17, 1965*: This meeting will be held early in 1965 with the legislative theme in mind. Arrangements have been made for the President of the AMA to be a guest speaker, and Dr. Roy Lester of the AMA Washington Office will be present. The meeting will be held at the Riviera Motel, in Atlanta.

(5) *State Legislation*: MAG will be seeking approval of legislation in the following fields: Anti-Child Abuse; Voluntary Sterilization; Implementation of the Second Phase of Kerr-Mills; MAG will cooperate with State Committee on Traffic Safety to have enacted legislation in the field of more restrictive issuance of drivers' licenses; and will also cooperate on certain church-sponsored legislation to curb the traffic in marriages in Georgia. A visit to the Governor on December 16, by Drs. McDaniel, Alexander, Mauldin, Goodwin, Lester Harbin and John Bell will be made to urge implementation of the second phase of Kerr-Mills.

*AMA Delegates Report*: Dr. J. W. Chambers reported on the following items of interest at the recent AMA Clinical Session, Miami, Florida, November 29-December 2, 1964:

- (1) The address by Dr. Donovan Ward, President of AMA;
- (2) The election of Dr. James Z. Appel, as President-Elect of AMA;
- (3) The Medicare policy of AMA;
- (4) The Commission on Cost of Medical Care;
- (5) The communications system regarding installation of teletype equipment in each state association office;
- (6) AMA-ERF progress;
- (7) Dues raise was not recommended;
- (8) Tribute to Dr. and Mrs. Eustace A. Allen, as this was Dr. Allen's last AMA meeting as a delegate from MAG.

*Relative Value Study Committee Report*: Dr. Pinson, Chairman, gave a detailed report, and after a complete explanation of the method used, moved that Council recommend to the MAG House of Delegates approval of the 1964 revision of the California Relative Value Schedule for MAG with preamble changes to all of the sections and a revision of the radioisotope section as recommended by Dr. Silverstein. Method of transmission will be as follows:

A copy to each county medical society president and secretary, and a copy to each delegate and member of Council. This would be a total of about 400 copies, which would have to be purchased from the California Medical Association. A covering letter to be mailed with the schedule should be signed by the Chairman of Council.

Voted to accept Executive Committee's action concerning the renegotiation of VA fee schedules, which consisted of consulting specialists in the field of surgery, medicine, radiology and pathology and approving the conversion factors recommended.

Voted to accept the installation of a teletype in the association office for communication with state associations and the AMA offices in Chicago and Washington. Installation and monthly



rental to be paid by AMA; MAG cost would consist only of sending messages.

Disaster Medical Care Committee Mailing: Voted to mail a letter to each county medical society president and to the Chief of Staff of each hospital in Georgia regarding the organization of physician teams for disaster medical care where needed.

Recommended that MAG Insurance and Economics Board investigate trip insurance for MAG officers, members, and staff on official association business.

#### "RESOLUTION

WHEREAS, a long range mental health program is being instituted for implementation in the State of Georgia, and

WHEREAS, the Division of Mental Health of the Georgia Department of Public Health is requesting the cooperation and participation of the professional and civic organizations in this planning effort, and

WHEREAS, Pharmacists and the profession of Pharmacy are not represented on the State Mental Health Planning Committee, and

WHEREAS, they are not mentioned in the local health planning efforts, and

WHEREAS, The implementation of any mental health program is going to necessitate the use of the many new and extremely potent drugs used in this field; therefore be it

RESOLVED, that this program would be remiss in its duty to safeguard the public health if it did not utilize the profes-

sional services of the pharmacists of the State of Georgia, and be it further

RESOLVED, that the Interprofessional Council of Georgia respectfully requests that pharmacists be included on the State Mental Health Planning Committee as well as on the planning committees at the local level, and be it further

RESOLVED, that copies of this resolution be forwarded to Dr. Addison M. Duval, Director, Division of Mental Health, Georgia Department of Public Health, Dr. Luther Terry, Surgeon General, U. S. Public Health Mental Planning Committee, and to the chairman of the local mental health planning committees in the State of Georgia.

Adopted: December 9, 1964

Interprofessional Council of Georgia  
Atlanta, Georgia

(Motion—George Mudter Second—Dr. Dan Cabaniss)"

On motion duly made and seconded the resolution was approved.

Ad Hoc Committee to Study Drafting of a Physician-Pharmacist Code of Understanding: Approved C. Daniel Cabaniss, M.D., and William A. Wood, M.D. as representatives on this committee.

Recommended that MAG Attorney, John Moore, write an article on blood transfusions for members of certain religious sects who may refuse transfusions on religious grounds, for publication in *JMAG*.

## THE BUSINESS OF DRUG TESTING

Francis Boyer, chairman of the board of Smith Kline and French Laboratories, in a special article . . . indicates additional hazards associated with the clinical testing of new drugs as a result of the 1962 amendments to the previously existing food and drug legislation. Not only is the physician thus engaged subjected to a greatly increased burden of paper work, but also to the so far unpredictable possibility of legal action,

since the FDA certificate that he is required to submit states that his patients are being used for the purpose of investigating new drugs, with no indication that they may be benefited thereby. Certainly, a tangled web seems to have been woven in the effort to ensure that all drugs reaching the market are both reasonably safe and reasonably effective. — Editorial in *New England Journal of Medicine*, 270: 15, (April 9,) 1964.

## RESOLUTION — IN MEMORIAM

WHEREAS: The Glynn-Brunswick Memorial Hospital is grieved by the death of Dr. Joseph B. Mercer, and

WHEREAS: Dr. Mercer's diligent and thorough attention to the needs of his patients, as attested by their love for him, is so well known to this medical staff, and

WHEREAS: He has served his staff faithfully, not alone in his professional capacity, but cheerfully and at great sacrifice of his time, in countless official and committee duties, thus sharing with us the benefit of his administrative talents, and

WHEREAS: Dr. Mercer has given our medical staff superior representation at the county, district and state levels, having served as president of the Clayton County Medical Society, the Eighth District Medical Society and the Georgia Chapter of the American Academy of General Practice, and was serving as Vice-Speaker of the House of Delegates of the Medical Association of Georgia, and

WHEREAS: The esteem of the whole community for him was evidenced by his election to the city commission and later to the office of Mayor of Brunswick, posts in which he served as one unusually well qualified and where he distinguished himself by his staunch and unwavering leadership to move our community ahead, and

WHEREAS: Through all the demands made upon his time, he was a devoted husband and father, a friend of all classes, and was particularly concerned with the needs of youth and their welfare. In his work with them, he leaves his mark indelibly inscribed upon our community life.

NOW, THEREFORE, BE IT RESOLVED: That the Medical Staff of the Glynn-Brunswick Memorial Hospital expresses its deep affection for the many facets of the life and example of Dr. Mercer, and that we draw inspiration from the works of one so dedicated to the practice of medicine, and, more importantly, to the practice of living and serving our fellow men.



# THE ASSOCIATION



## DEATHS

JOSEPH B. MERCER, 39-year-old Brunswick major, was killed in an automobile collision December 12, 1964. Dr. Mercer was traveling alone to attend an MAG council meeting in Albany when the accident occurred.

He was a member of the American Academy of General Practice and president-elect of the Medical College of Georgia Alumni Association.

A native of Jasper Co., Georgia, Dr. Mercer came to Brunswick 12 years ago.

Among survivors are his wife, Kathryn; a son, Steve, and a daughter, Paige.

He was associated in medical practice with Drs. W. O. Inman and Willard Snyder.

MONTAGUE LAFAYETTE BOYD, SR., Atlanta urologist, died January 9, 1965. He was 82.

Dr. Boyd had served as an associate professor of urology at the Atlanta Medical School before World War I and later as head of the Department of Urology at the postgraduate school of Emory University, head of the Steiner Cancer Clinic in Atlanta and head of the Department of Urology at Piedmont Hospital from 1919 until his retirement in 1959. The Urology Department there is named in his honor.

He earned a Ph.D. at Emory College at Oxford in 1903 and his M.D. from Johns Hopkins Medical School in 1907.

After several assistantships in the field of urology he began his practice in Atlanta in 1911.

At the outbreak of World War I he became a captain in the U.S. Army Medical Reserve Corps and was appointed a member of a special commission to study urological conditions in the British and French armies.

In 1917 he sailed on the S.S. Baltic, the first ship to go abroad in World War I. Gen. John Pershing was among those making the voyage.

Dr. Boyd was a member of Chi Phi and Phi Beta Kappa. While at Johns Hopkins he was a member of the Pitotomy Club.

He also was a member of the Piedmont Driving Club and the Savannah Yacht Club.

Survivors are his widow, the former Margaret Phillips of LaGrange; a son, Montague L. Boyd, Jr.; a daughter, Mrs. Rhodes L. Purdue, both of Atlanta; sister, Mrs. Einar S. Trosdal of Savannah; brother, Walter R. Boyd of Miami; seven grandchildren and nieces and nephews.

PHILIP A. MULHERIN, 58-year-old Augusta doctor, died in December, 1964, after several weeks of illness.

A graduate of the University of Georgia, he continued his medical education at the Medical College of Georgia, graduating in 1930. He interned in Chicago, Illinois.

Dr. Mulherin served as a lieutenant colonel during World War II with the First Evacuation Hospital in

Europe. He was vice president of the Augusta Golf Association, and former vice president of the Board of Governors at the Augusta Country Club.

Dr. Mulherin was the medical representative on the Red Cross board at the time the volunteer blood transfusion program was started in 1937, and was instrumental in its organization.

He was the pediatric consultant for Ft. Gordon's U. S. Army Hospital; a clinical professor of pediatrics at the Medical College of Georgia, and a faculty member of the Southern Pediatrics Seminar.

He was a member of the advisory board for the Georgia Association for Crippled Children and held membership in the Richmond County Medical Society, the American Board of Pediatrics, the American Medical Association, the Academy of Pediatrics and the Georgia Pediatric Society.

Survivors include his wife, Mrs. Elizabeth Hill Mulherin; two daughters, Miss Beverly Mulherin, Augusta; Mrs. George Scott of Ashburn, Georgia; one son, Dr. William B. Mulherin; a brother, William A. Mulherin, Jr.; four grandchildren and a number of nieces and nephews.

VIRGIL P. SYDENSTRICKER, Augusta, died December 12, 1964. He was recognized for outstanding work in the fields of general medicine and nutrition.

Recognition came to him through his selection to deliver the Thayer Lecture at Johns Hopkins Medical School, the Wyckoff Lecture at New York University School of Medicine, the Campbell Lecture at Queens University in Belfast, Northern Ireland, and the Lind Bicentennial Lecture at Edinburgh, Scotland.

During World War II he was adviser to the British Ministry of Health, for which he received the King's Medal. Later he served in the National Research Council's nutritional division, was consultant to the Surgeon General of the U. S. Army and in 1950 was appointed by the World Health Organization to evaluate post-war nutrition in England.

He was a member of the Medical College of Georgia faculty from 1920 until his retirement in 1957; and, after that, in clinical medicine at the Veterans Administration Hospital.

## SOCIETIES

W. Earl Lewis, M.D., has been installed as President of the BIBB COUNTY MEDICAL SOCIETY for 1965. Other officers are H. K. Sealy, M.D., President-elect; R. W. Edenfield, M.D., Parliamentarian; Braswell E. Collins, M.D., Past President; J. T. DuPree, M.D., Secretary; and Z. S. Sikes, Vice-President.

C. H. Harper, M.D., Folkston, was elected President of the CAMDEN-CHARLTON COUNTY MEDICAL SOCIETY for the year 1965 at a December meeting



held in Kingsland. Also elected were J. O. Simmons, M.D., Woodbine, Vice President; and Harry Robinson, M.D., Kingsland, Secretary.

**COFFEE COUNTY MEDICAL SOCIETY** has elected the following officers for 1965: Calvin S. Meeks, M.D., President; Dick Benson, M.D., Vice President; and John W. Herndon, M.D., Secretary-Treasurer.

The following officers were elected for the year 1965 by **ELBERT-FRANKLIN-HART COUNTY MEDICAL SOCIETY**: President, Carey Mickel, M.D.; Vice-President, M. M. Dalton, M.D.; and Secretary-Treasurer, John N. Shearouse, M.D.

New Officers for 1965 for **FULTON COUNTY MEDICAL SOCIETY** are John T. Godwin, M.D., President-elect; Lamar Peacock, M.D., President; William D. Logan, M.D., Vice-President; and J. Frank Walker, M.D. and Ray Dellinger, M.D., Board of Trustees. Named to the council of the Medical Association of Georgia was Linton H. Bishop, M.D.; and Harold Harrison, M.D., and Fleming Jolley, M.D., were named vice-councilors.

Jules Victor, M.D. has been elected as President-elect of the **GEORGIA MEDICAL SOCIETY**. Robert B. Gottschalk, M.D., was installed as the new President; W. W. Osborne, M.D. as Vice-President; and re-elected to office were J. J. Dooan, M.D., Treasurer, and Jeff J. Holloman, M.D., Secretary.

W. W. Payne has been elected President of the **GLYNN COUNTY MEDICAL SOCIETY**. Named President-elect was Robert E. Perry, M.D., and Vice-President E. A. Daneman, M.D. Pearl B. Waddell, M.D., will serve as Secretary and Charles Jarrett as Treasurer. **MAG** Delegates will be C. S. Britt, M.D. and Bert Malone, M.D.

Newly elected officers for **RANDOLPH-STEWART-TERRELL COUNTY MEDICAL SOCIETY** are George Patterson, M.D., Cuthbert, President; Charles Sheffield, M.D., Dawson, Vice-President; and Carl Sills, M.D., Cuthbert, re-elected Secretary-Treasurer for the third year.

**SOUTH GEORGIA MEDICAL SOCIETY** had as their guest speaker for the December meeting a specialist in aerospace medicine, Col. Raymond A. Yerg of Patrick Air Force Base, Florida. He discussed the medical aspects of the missile and space program.

Jack Griffin, M.D., Columbus neurosurgeon, was the guest speaker at a recent meeting of the **SOUTHWEST GEORGIA MEDICAL SOCIETY** in Blakely. He discussed arteriograms of the brain as an aid in diagnosis.

Michael E. DeBakey, Professor and Chairman of the Department of Surgery at Baylor University College of Medicine, Houston, Texas, will be the featured guest speaker at a symposium on cardiovascular diseases sponsored by the **THIRD DISTRICT MEDICAL SOCIETY** and Lederle Laboratories. The meeting is slated for April.

## PERSONALS

### First District

Georgia Medical Society, Savannah, has recently acquired a new Executive Secretary. She is Mrs. Lee Giffen, a native Georgian, who attended the Woman's College of Georgia, received a masters in Journalism from Columbia University, and has been a member of the Editorial staffs of the *Augusta Chronicle* and the *Atlanta Journal*. She has served on the Washington Bureau of UPI, been an administrative assistant for a Congressman, and done free-lance writing, some of which has been published nationally. In addition to her newly acquired duties as Executive Secretary, Mrs. Giffen will continue to do free-lance writing.

### Third District

J. C. SERRATO, Columbus orthopedic surgeon who is also orthopedic consultant to Meriwether Memorial Hospital and a member of the Advisory Board of Directors of The White House Inn, Inc., of Warm Springs, recently became a fellow in the International Academy of Law and Science.

JACK C. HUGHSTON, Columbus, has recently been elected Vice-Chairman of the Section on Orthopedic and Traumatic Surgery of the Southern Medical Association, Birmingham.

### Fifth District

HIRAM M. STURM was recently elected president of the Atlanta Dermatological Association and ROBERT M. FINE was elected secretary. Both attended the joint meeting of the Alabama-Georgia Dermatological Association in Birmingham.

DRS. SIDNEY OLANSKY, MARY LOU APPLEWHITE and MARIAN OLANSKY, Atlanta, attended the meeting of the Southern Medical Association in Memphis. DRS. APPLEWHITE and S. OLANSKY, Secretary of the section, participated in the dermatology section meeting. Dr. Sidney Olansky was moderator and participant in a symposium on venereal diseases.

CHARLES EBERHART of Atlanta has been named Chairman of a Joint Liaison Committee of Georgia physicians and nurses to study problems common to both groups and to offer suggestions to improve patient care.

EDGAR BOLING, Atlanta, has been appointed to the Council of the Southern Medical Association, Birmingham.

Fulton County Medical Society recently honored JOHN YAUGER and ALBERT RAYLE, JR., Atlanta, with the Aven Citizenship Cup for outstanding achievement in civic and medical activities during 1964. They were honored for their work in behalf of the Sabin Oral Sunday campaign against polio.



SIDNEY OLANSKY, Atlanta, has been made Secretary of the Section on Dermatology of the Southern Medical Association, Birmingham.

#### Seventh District

MARY C. WARD of St. Simon's Island is now associated with DR. HOWARD M. SIGAL and LEE J. KNIGHT in the practice of pediatrics at the Children's Medical Center in Smyrna and the Emory Howard Medical Building in Mableton.

#### Eighth District

J. W. YEOMANS, Jesup, has been elected to a three-year term on the Jesup city commission.

The Ware County Association of Medical Assistants had as their guest speaker NEAL YEOMANS, Waycross, who discussed the need for a continued push for knowledge in the medical fields.

#### Ninth District

P. K. DIXON, Gainesville, spoke to the Gainesville Rotary Club in December. Dr. Dixon, who is a member of the State Board of Health, spoke on the Kerr-Mills program as opposed to the King-Anderson bill.

#### Tenth District

GUY O. WHELCHER, Athens, was honored recently by his medical colleagues with a bronze plaque for his long years of faithful service.

The appointment of MARSHALL B. ALLEN, JR., as Professor of Surgery and Chief of the Division of Neurosurgery has been announced by the Medical College of Georgia. He comes to the Georgia medical campus from the Veterans Administration Center, Jackson, Mississippi, where he was Chief of neurological service.

### COOPERATION IN DRUG INVESTIGATION

As the new drug is being introduced on the market and becomes generally available, the pharmaceutical manufacturer loses his tight control over its use, and a major part of the responsibility for the judicious application of the compound now rests with the medical profession and the scientific organizations and societies interested in drug therapy. It is therefore hoped that the many local, national, and international organiza-

tions which are concerned with effects and adverse reactions of drugs will join with the pharmaceutical manufacturer and the government agencies charged with surveillance of drugs in an effort to assure the most beneficial and the safest application of our modern chemical weapons against disease. — Gerhard Zbinden, M.D., in *Clinical Pharmacology and Therapeutics*, 5: 5, (Sept.-Oct.) 1964.

### GEORGIA DOCTORS URGED TO INCLUDE "SAFETY SHOTS" IN THEIR IMMUNIZATION SCHEDULES

Georgia's doctors are being asked to include "safety shots" in immunization schedules for their young patients.

The "safety shots" are educational tools being offered to all state physicians who provide well-child care to their patients. Pamphlets, posters and other literature stressing accident prevention are being made

available to doctors as part of a safety campaign begun 18 months ago.

Sponsored by the Georgia chapter of the American Academy of Pediatrics, the Georgia Pediatrics Society, the Georgia Academy of General Practitioners and the Georgia Department of Public Health, the program is aimed at the one to five age group. A high percentage of pediatric accidents occurs at this pre-school age level and the sponsoring agencies decided to concentrate on this danger zone.

#### Stress on Safety

The child's doctor has many opportunities during well-child visits to stress safety to parents. With special literature readily available, the sponsoring groups feel that physicians may now include "safety shots" in their schedules. Doctors who have evolved their own safety programs may, of course, also use the literature.

In the campaign so far, mail contact has been made with all physicians in Districts I, III, V, VI, VII, IX and X known to administer to children. Physicians in the remaining three districts will also be contacted by mail in the near future.

Any doctor who has not received the educational materials for the well-child accident control program in Georgia may do so by mailing the coupon at left.

#### DOCTORS ACCIDENT PREVENTION PROGRAM

For Literature Packet, Mail Coupon to:

DR. ROBERT M. FLOWERS, Chairman  
GEORGIA CHAPTER — AMERICAN ACADEMY OF  
PEDIATRICS  
1315 DE LAUNY AVENUE  
COLUMBUS, GEORGIA

MAIL LITERATURE TO:

DR. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DISTRICT NO. \_\_\_\_\_



**JOURNAL**  
OF THE MEDICAL  
ASSOCIATION

MARCH 1965  
*Georgia*

Public Health

Radiology

Thoracic Surgery

Anesthesiology



Dermatology

OB-GYN

Diabetes

Donald L. Rasmussen  
Beckley, W. Va.

Colin B. Holman  
Rochester, Minn.

Donald L. Paulson  
Dallas, Tex.

Leonard W. Fabian  
Jackson, Miss.



Diabetes

Psychiatry

Orthopedics

OB-GYN

Robert A. Berger  
New York, N. Y.

Richard L. Burt  
Winston-Salem, N. C.

Priscilla White  
Boston, Mass.



Cardiology

OB-GYN

Abner W. Calhoun  
Memorial Lecture

John Buse  
Charleston, S. C.

Marion B. Richmond  
Kensington, Md.

Frank H. Stelling  
Greenville, S. C.

Michael Newton  
Jackson, Miss.



Frank A. Finnerty  
Washington, D. C.

Edward J. Dennis  
Charleston, S. C.

William B. Bean  
Iowa City, Iowa

**111th Annual Session**

**AUGUSTA**  
**MAY 2-4, 1965**





## epilepsy can undermine self-reliance

"A therapeutic 'bull's-eye' may be scored with DILANTIN [diphenylhydantoin] even for a person with long-standing convulsions previously unrelieved by phenobarbital."\* Such efficacy can make a substantial contribution to your epileptic patient's rehabilitation...improve his prospects for employment...foster greater self-reliance.

**Indications:** Grand mal epilepsy and certain other convulsive states. **Precautions:** Toxic effects are infrequent: allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Eruptions then usually subside. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hir-

sutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Megaloblastic anemia, aplastic anemia, leukopenia, granulocytopenia and pancytopenia have been reported. Nystagmus may develop. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. Adequate examination of the blood is advisable. DILANTIN (diphenylhydantoin sodium) is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm.

\*Lennox, W. G.: Epilepsy and Related Disorders, Boston, Little, Brown and Company, 1960, vol. 2, p. 865.

**PARKE-DAVIS**

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232

# Dilantin®

(diphenylhydantoin)

PARKE-DAVIS

## helps to restore confidence



JOURNAL  
OF THE MEDICAL  
ASSOCIATION

Georgía

Contents

EDITOR

Edgar Woody, Jr., M.D.

MANAGING EDITOR

Merrilie M. Davis

STAFF

Thelma V. Franklin, *Business*

CONTRIBUTING EDITORS

Herbert S. Alden, M.D.; Preston D. Ellington, M.D.; Thomas Findley, M.D.; J. Willis Hurst, M.D.; Charles S. Jones, M.D.; Arthur M. Knight, Jr., M.D.; Arthur J. Merrill, M.D.; Lester Rumble, Jr., M.D.; Peter L. Scardino, M.D.; Patrick C. Shea, Jr., M.D.; Robert H. Vaughan, M.D.

PUBLICATIONS COMMITTEE

J. G. McDaniel, M.D.; George H. Alexander, M.D.; George R. Dillinger, M.D.; John Kirk Train, M.D.; A. W. Simpson, M.D.; John T. Mauldin, M.D.; John S. Atwater, M.D.; C. R. Andrews, M.D.

THE ASSOCIATION

J. G. McDaniel, M.D., *Pres.*; George H. Alexander, M.D., *Pres.-Elect*; George R. Dillinger, M.D., *Past Pres.*; A. W. Simpson, M.D., *Chm. of Council*; John T. Mauldin, M.D., *Sec.*; John S. Atwater, M.D., *Treas.*; J. Frank Walker, M.D., *Speaker*; Mr. Milton D. Krueger, *Exec. Sec.*; Mr. James M. Moffett, *Asst. Exec. Sec.*; Mrs. Catherine Wooten, *Asst. Exec. Sec.*

THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and copyrighted, 1965, by the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309. Published monthly under the direction of the Council of the Association. Subscription rate: \$7 per year; \$1 per single copy. Second-class postage paid at Atlanta, Georgia.

1965 MAG Annual Session

MOTEL AND HOTEL RESERVATIONS . . . . .	68
OFFICIAL CALL . . . . .	69
CALL FOR SCIENTIFIC EXHIBITS . . . . .	71
PROGRAM RESUME . . . . .	72
ANNUAL SESSION SECTION CHAIRMEN . . . . .	72
THE PROGRAM . . . . .	73
GUEST SPEAKERS . . . . .	77
MAG OFFICERS, COMMITTEES AND BOARDS . . . . .	83
DISTRICT SOCIETY OFFICERS . . . . .	85
SPECIALTY SOCIETY OFFICERS . . . . .	85
COUNTY SOCIETY OFFICERS . . . . .	86
WOMAN'S AUXILIARY—PROGRAM AND OTHER DATA . . . . .	87

Scientific Articles

COMPLICATIONS OF ENDOSCOPY John B. Blalock, M.D. . . . .	92
TUBERCULOSIS WITHIN THE FAMILY UNIT Paul A. Pamplona, M.D. . . . .	96
WELL BABY CARE: UNTAPPED PORTAL OF ENTRY TO FAMILY CARE Caroline A. Chandler, M.D. . . . .	99

Editorials

WELCOME TO AUGUSTA . . . . .	103
AMA DELEGATES SPECIAL SESSION . . . . .	103

Features

PRESIDENT'S LETTER . . . . .	105
CANCER PAGE . . . . .	106
HEART PAGE . . . . .	107
ABSTRACTS . . . . .	108

The Association

DEATHS . . . . .	109
SOCIETIES . . . . .	109
PERSONALS . . . . .	109
ADVERTISING INDEX . . . . .	46A
CALENDAR . . . . .	81

Cover

Design by John Stuart McKenzie, Atlanta



Printers of the  
**JOURNAL**  
OF THE MEDICAL  
ASSOCIATION  
OF GEORGIA  
and other publications  
of distinction

**HIGGINS-  
MCARTHUR**  
*Company*

302 Hayden Street, N.W.  
Atlanta 13, Georgia

**Hygroton®**  
brand of chlorthalidone  
the long-acting diuretic

## Geigy

Indications: Many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity, and most cases of severe renal or hepatic disease.

Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Side Effects: Constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, leukopenia, muscle cramps, nausea, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.

Average Dosage: One tablet (100 mg.) daily with breakfast.

Availability: Tablets of 100 mg. in bottles of 100 and 1000.

For full details, see the complete prescribing information.

Geigy Pharmaceuticals  
Division of  
Geigy Chemical Corporation  
Ardsley, New York Hy-3416

*when the patient asks*



"What douche  
should I use,  
Doctor?"

ETHICALLY PROMOTED

**Meta Cine®**

mucohytic, acidifying, physiologic vaginal douche

**SEND FOR SAMPLES**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*Brayten* PHARMACEUTICAL CO.  
CHATTANOOGA, TENN. 37409



**JOURNAL**  
OF THE MEDICAL  
ASSOCIATION

MARCH 1965  
*Georgia*

Public Health



Donald L. Rasmussen  
Beckley, W. Va.

Radiology



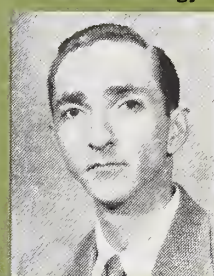
Colin B. Holman  
Rochester, Minn.

Thoracic Surgery



Donald L. Paulson  
Dallas, Tex.

Anesthesiology



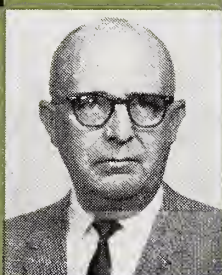
Leonard W. Fabian  
Jackson, Miss.

Dermatology



Robert A. Berger  
New York, N. Y.

OB-GYN



Richard L. Burt  
Winston-Salem, N. C.

Diabetes



Priscilla White  
Boston, Mass.

Diabetes



John Buse  
Charleston, S. C.

Psychiatry



Marion B. Richmond  
Kensington, Md.

Orthopedics



Frank H. Stelling  
Greenville, S. C.

OB-GYN



Michael Newton  
Jackson, Miss.

Cardiology



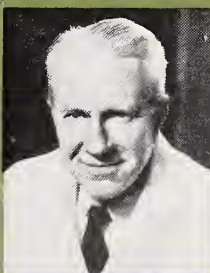
Frank A. Finnerty  
Washington, D. C.

OB-GYN



Edward J. Dennis  
Charleston, S. C.

Abner W. Calhoun  
Memorial Lecture



William B. Bean  
Iowa City, Iowa

**111th Annual Session**

**AUGUSTA**  
**MAY 2-4, 1965**

# For Your MAG 1965 Annual Session Hotel & Motel Reservations

## APPLICATION FOR HOTEL AND MOTEL ACCOMMODATIONS

Medical Association of Georgia 111th Annual Session

May 2-4, 1965 — Augusta, Georgia

A HOUSING BUREAU has been established for your convenience in making hotel and motel reservations at Augusta for the 1965 Annual Session of the Medical Association of Georgia. Comparable room rates and accommodation information are listed. *Use the Reservation Form below.* Please specify your first, second and third choice hotel or motel. All requests for reservations should give: (1) anticipated date and hour of arrival; (2) date and approximate hour of departure; (3) names and addresses of all persons who will occupy the accommodations. All reservations must be cleared through the Housing Bureau. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible to secure the accommodations you request. All reservations will be confirmed.

**Augusta Town House:** Broad at Albion St. (722-5541).  
Single \$7 up, double \$8.50 up, twin beds \$9.50 up.  
100% Air Conditioned, Swimming Pool, TV-Radio,  
Free inside parking, barber and beauty shop, two  
cocktail lounges, two restaurants, newstand, Gift  
Shop, package shop — Heart of Augusta — 300  
Rooms.

**Downtowner Motor Inn:** Reynolds at 8th St. (722-5361).  
Single \$8 up, double \$10.50 up, twin beds \$12.00  
up. 100% Air Conditioned, Radio — TV, Free  
parking. Swimming pool, Cocktail Lounge, Restau-  
rant — 100 rooms.

**Warrick — Quality Motel:** Broad at 4th St. (722-0212).  
Single \$8 up, doubles \$10, twin beds \$12. Air Con-  
ditioned — TV, Free Parking, Free Continental  
Breakfast. Cocktail Lounge — 69 Rooms.

**University Motel:** 1410 Gwinett St. (724-8204). Single \$7  
up, double \$9 up, twin beds \$10 up. Air Conditioned.

— TV, Free parking, Restaurant near-by, Adjacent  
Talmadge Memorial and University Hospitals —  
68 Rooms.

**Medical Center Motel:** 1480 Gwinett St. (722-4828). Single  
\$7 up, double \$9 up, twin beds \$10 up. Air Con-  
ditioned — TV, Free Parking, Restaurant next  
door, Adjacent Talmadge Memorial and University  
Hospitals — 45 Rooms.

**Howard Johnson Motor Lodge:** 1238 Gordon Highway.  
(724-9613). Single \$9 up, double \$12 up, twin beds  
\$13. Air Conditioned — TV, Swimming Pool, Free  
parking, Restaurant and Cocktail Lounge — 61  
Rooms.

**Holiday Inn:** 1602 Gordon Highway. (798-2782). Single  
\$7 up, double \$11 up, twin beds \$11 up. Air Con-  
ditioned — TV, Swimming Pool, Restaurant, Cock-  
tail Lounge, Free Parking — 110 Rooms.

Confirmation of your request for accommodations will be in accordance with preference indicated, if possible; if not, best substitutes will be made.

Cut out and send to:

Please Type or Print

HOUSING BUREAU, MEDICAL ASSOCIATION OF GEORGIA

Augusta Town House, Augusta, Georgia — Attn: Otis Phillips, Vice-President — Sales

Please reserve the following accommodations for the 1965 Annual Session of the  
Medical Association of Georgia.

### Hotel or Motel Preference

1st Choice ..... ☐ Double Room at \$ ..... to \$ .....  
2nd Choice ..... ☐ Double Room at \$ ..... to \$ .....  
3rd Choice ..... ☐ Twin Bedroom at \$ ..... to \$ .....  
..... ☐ Other type .....

Arrival Date ..... Hour ..... A.M. .... P.M.

Departure Date ..... Hour ..... A.M. .... P.M.

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Include all names of all persons for  
whom you are requesting reservations and who will occupy the room(s):

Name of Occupant(s)

Address

.....  
.....  
.....

### Individual Requesting Reservations

Name .....

Address .....

City ..... State .....

Zip Code .....

*If hotels or motels of your choice are unable to  
accept your reservations, the Housing Bureau  
will make reservations to fit your specifications  
elsewhere.*



# 111th Annual Session Official Call

## Extended to All Officers and Members of the Medical Association of Georgia

### Specific Information

**T**HE OFFICIAL CALL for the 111th Annual Session of the Medical Association of Georgia is hereby extended to all Association members. This two and one-half day meeting will be convened May 2, 3, and 4 at the Augusta Town House Motor Hotel, Augusta, Georgia. The Association will conduct scientific sessions and general business meetings, and the House of Delegates will be convened for their annual meeting. Scientific and Commercial exhibits will be on display in the Augusta Town House adjacent to the main meeting rooms. Social events for the membership have been planned and many of the Specialty Societies will have their own luncheon and dinner meetings. The Woman's Auxiliary to the Medical Association of Georgia will hold their 40th Annual Convention in conjunction with the Association Annual Session at the Augusta Town House.

### Registration

The MAG Official Registration Desk will be located on the second floor of the Augusta Town House adjacent to the French Room. The French Room, Spanish Room and Italian Room will serve to house the MAG Scientific and Commercial Exhibits and will be used as the entrance and exit to the Embassy Room which is the main meeting room for the session. Other meetings will convene in the Boxwood Room and the Teakwood Room which are also on the second floor of the Augusta Town House.

The Registration Desk will be open for registration of MAG members and their guests on Sunday, May 2 from 1:00 p.m. to 6:00 p.m.; Monday, May 3 from 8:00 a.m. to 5:00 p.m. and Tuesday, May 4 from 8:00 a.m. to 4:00 p.m.

MAG members and guests are requested to register at the MAG Registration Desk *immediately on arrival* at the Augusta Town House to obtain badges and programs. No one will be admitted to the Exhibit Hall, Meeting Rooms or other MAG functions without MAG Official registration badges.

### MAG Scientific Sessions—

MAG Scientific Section and Joint Section Meetings will convene Sunday afternoon, May 2 from 2:00 p.m. to 4:30 p.m.; Monday morning, May 3 from 10:30 a.m. to 1:00 p.m. and Tuesday morning, May 4 from 9:00 a.m. to 1:00 p.m. The Abner W. Calhoun Memorial Lectureship is scheduled for all physicians on Tuesday morning, May 4 at 12:00 noon to 1:00 p.m. No official MAG Section or Joint Section meetings are scheduled for Monday afternoon, May 3.

### MAG General Business Sessions Embassy, Boxwood & Teakwood Rooms

The Association will convene its first General Business Session for all MAG members on Sunday after-

noon, May 2 at 4:30 p.m. at which time nominations for MAG Offices will be made. The second General Business Session will be held jointly with the MAG House of Delegates meeting on Monday morning, May 3 at 9:00 a.m. to 10:30 a.m. During this business session the MAG President-Elect will outline his program for 1965-66. The third and final General Business Session will convene jointly with the MAG House of Delegates final meeting on Tuesday afternoon at 2:30 p.m. to 5:00 p.m. At this last business session, MAG awards will be presented, election results announced and new officers installed—and the entire 111th Annual Session will be adjourned.

### MAG House of Delegates Sessions— Embassy Room

The first session of the MAG House of Delegates will meet Monday morning, May 3 at 9:00 a.m. to 10:30 p.m. At this session all reports and resolutions will be introduced to the House for referral to House Reference Committees.

All Reference Committees of the House will meet concurrently on Monday afternoon, May 3 in the Embassy Room from 2:30 p.m. to approximately 5:00 p.m. Delegates and all MAG members are urged to attend these Reference Committee meetings so that they may make their views known to assist these Committees in their deliberations on those items of business before the Association House of Delegates. The second and final session of the MAG House of Delegates will convene Tuesday afternoon, May 4 at 2:30 p.m. to 5:00 p.m. At this last session, the House Reference Committees will report their recommendations and the House will vote on these items of business which set MAG policy for 1965-66. Both sessions of the House will be held jointly with the MAG General Business sessions to facilitate the overall business of the Association.

Delegates are urged to attend both sessions of the House to fulfill their responsibility to the County Medical Society which they represent. *All Delegates are requested to attend both sessions of the House at least 15 minutes prior to the time they are convened so that Delegates may be registered without delay of the meetings.* Registration of MAG Delegates will be conducted at a SPECIAL DELEGATES REGISTRATION DESK just inside the Embassy Room 30 minutes preceding the convening of both sessions of the House so that attendance and voting privileges may be checked by the House Credentials Committee. *During this Delegates Registration, Special Badges will be given Delegates.* As both sessions of the House will be held jointly with MAG General Business Sessions, *special seated areas will be reserved for Delegates* and their Special Badges will admit them to this separate section of the meeting room.



## MAG Message Center

A Message Center will be maintained at the MAG Official Registration Desk for the convenience of the membership. Pages from the Woman's Auxiliary to MAG will staff this center during the entire session for incoming messages only.

An Official Bulletin Board at this message center will be available for notices of special importance during the Annual Session.

## MAG Headquarters Office and Press Room

The Association Headquarters Office Staff will maintain a Headquarters Office Room adjacent to the French Room on the second floor of the Augusta Town House for the purpose of staff secretarial activities in conjunction with the conduct of Association business during the meeting.

An MAG Press Room will also be available for newspaper, radio and T.V. personnel during the entire meeting. This room will be adjacent to the MAG Headquarters Office on the second floor of the Augusta Town House.

## MAG Memorial Services

The Medical Association of Georgia will hold its traditional annual Memorial Services at the first Joint General Business and House of Delegates Sessions on Monday morning, May 3 at 9:00 a.m. in the Embassy Room. All members and their guests are invited to attend this service which is held in memory of those members who have died during the past Association year. The event will honor and recall the service and contributions of the following medical practitioners:

Thomas Arthur Amburgey, Savannah, October 10, 1964  
M. K. Bailey, Atlanta, June 21, 1964  
W. G. Bannister, Rome, January 13, 1965  
L. Minor Blackford, Atlanta, May 5, 1964  
Montague Lafayette Boyd, Atlanta, January 9, 1965  
James M. Burdine, Atlanta, November 4, 1964  
Arthur William DeLoach, Waycross, October 24, 1964  
Murdock Sykes Euen, Atlanta, November 11, 1964  
William H. Good, Toccoa, June 30, 1964  
William H. Hadaway, LaGrange, July 26, 1964  
D. L. Head, Sr., Zebulon, February 3, 1965  
W. D. Jennings, Augusta, October 26, 1964  
Horace Greely Joiner, Douglas, April 30, 1964  
Martin L. Malloy, Vienna, August 23, 1964  
W. F. Massey, Chester, July 15, 1964  
Robert Ellis May, Lincolnton, August 23, 1964  
Paul McDonald, Bolton, July 23, 1964  
Joseph B. Mercer, Brunswick, December 12, 1964  
Clarence W. Mills, Jr., Atlanta, November 16, 1964  
J. L. Morris, Alpharetta, March 14, 1964  
Charles M. Mulherin, Augusta, May 14, 1964  
Phillip A. Mulherin, Augusta, December 1, 1964  
Elizabeth Peabody, Atlanta, February 18, 1965  
John H. Pinholster, Savannah, August 9, 1964  
John Ernest Powell, Sr., Villa Rica, September 8, 1964  
Earl Rasmussen, Atlanta, June 24, 1964  
Helen Sharpley, Savannah, February 19, 1965  
J. O. Simmons, Woodbine, January 6, 1965  
Donald W. Singleton, Atlanta, November 14, 1964  
George W. Smith, Augusta, April 18, 1964  
J. R. Smith, Hahira, December 5, 1964  
Phillip P. Sydenstricker, Augusta, December 12, 1964  
W. H. Tanner, Newnan, December 8, 1964  
E. M. Townsend, Ringgold, February 19, 1965  
J. C. Verner, Commerce, June 29, 1964  
O. S. Wood, Washington, May 23, 1964

## Specialty Society Meetings, Luncheons, and Dinners

Specialty Societies have planned meetings, luncheons, and dinners for the membership of their organizations to be held in conjunction with the MAG Annual Session. These events are listed in the Official MAG Program, in the order of the date and time the event is scheduled—under *Related Events*. As these sessions are limited to the membership of the specialty society sponsoring the affair, they are not considered a part of the MAG Program and are printed in "box form" in the MAG Program to distinguish them from the MAG sessions.

## MAG Social Events

Two social events are scheduled by MAG for the membership and their guests. The Richmond County Medical Society will host the membership at a Social Hour to be held on Monday evening, May 3 at 6:30 p.m. to 7:30 p.m., Swimming Pool Patio, in the second floor of the Augusta Town House. This Social Hour is sponsored through the courtesy of the Trust Company of Georgia, Atlanta, and affiliated banks: Augusta—First National Bank and Trust Company; Columbus—Fourth National Bank; Macon—First National Bank and Trust Company; North Atlanta—DeKalb National Bank of Brookhaven; Rome—First National Bank; and Savannah—Liberty National Bank and Trust Company.

The Medical Association of Georgia will honor its President at the traditional MAG President's Banquet to be held Monday evening, May 3, immediately following the Richmond County Medical Society Social Hour. The MAG President's Banquet will be a seated dinner with entertainment starting at 8:00 p.m. in the Embassy Room of the Augusta Town House. *As space for this banquet is limited, members are urged to purchase their banquet tickets on Sunday, May 2—at the MAG Registration Desk.* Accordingly, Banquet Tickets will be sold on a "first come—first served" basis.

A Social Hour limited to members of the MAG House of Delegates and their wives and Commercial Exhibitors and their wives will be held Sunday evening, May 2 at 5:30 p.m. in the Swimming Pool Patio on the second floor of the Augusta Town House. This Social Hour is sponsored by the Commercial Exhibitors in attendance at the 111th Annual Session and admission will be by ticket only. Tickets will be distributed to members of the MAG House of Delegates and Exhibitors prior to the Social Hour.

## Scientific Exhibits

Scientific Exhibits will be displayed adjacent to Commercial Exhibits in the French, Spanish and Italian Rooms of the second floor of the Augusta Town House. This Exhibit Hall will be used to gain entrance and exit to the main meeting room. The Scientific Exhibits are prepared by physicians who will be at their exhibits to discuss their presentation with the membership. All physicians are urged to visit each Scientific Exhibit in the interests of professional education. Awards for outstanding Scientific Exhibits will be presented at the final MAG General Business Session on Tuesday afternoon, May 4 at 2:30 p.m. in the Embassy Room.

## Commercial Exhibits

Approximately 42 Commercial Exhibits will be displayed in the French, Spanish, and Italian Rooms ad-



jacent to the Main Meeting Room (Embassy Room). The Exhibit Hall will be used to gain both entrance and exit to the Main Meeting Room. These exhibits will provide technical information of importance on products and services available to the medical profession.

*It is extremely important that every member visit each of these exhibits and register with the exhibitor. Your cooperation is requested in that these displays are designed specifically to benefit the profession. Commercial Exhibitors play an extremely important role in making the MAG Annual Session possible through their support of the meeting. Your MAG Commercial Exhibit Committee asks that physicians be sure to visit and register at all Commercial Exhibit booths.*

A list of Commercial Exhibitors already participating at this time in the MAG 111th Session is as follows:

Booth No.	Name of Firm
1	Wm. P. Poythress & Company, Inc., Richmond, Va.
2	Parke, Davis & Company, Detroit, Michigan
3	A. H. Robins Company, Inc., Richmond, Va.
5	Bristol Laboratories, Syracuse, New York
6	Carnrick Laboratories, Summit, N. J.
7	Carnation Company, Los Angeles, Calif.
8	Mead Johnson Laboratories, Evansville, Ind.
9	The Coca-Cola Company, Atlanta, Georgia
10	Delta Drug Corporation, Jacksonville, Fla.
11	Great Books of the Western World, Miami, Fla.
13	Schering Corporation, Union, N. J.
14	Sandoz Pharmaceuticals, Hanover, N. J.
15	Astra Pharmaceutical Products, Inc., Worcester, Mass.
16	Dictaphone Corporation, New York, N. Y.
17	Geigy Pharmaceuticals, New York, N. Y.
18	U.S. Vitamin & Phar. Corporation, New York, N. Y.
19	G. D. Searle & Co., Chicago, Ill.
20	Encyclopedia Britannica, Chicago
21	Warner-Chilcott Lab., Morris Plains, N. J.
22	Americana Corporation, Beverly Hills, Calif.
23	Ortho Pharmaceutical Corp., Raritan, N. J.
24	Hewlett-Packard Company, Walton, Mass., & Sanborn Division
25	
26	Pfizer Laboratories, New York, N. Y.
27	Dome Chemicals, Inc., New York, N. Y.
28	Gerber Products Co., Fremont, Michigan

- 29 CIBA Pharmaceutical Co., Summit, N. J.
- 30 Stansell's Oxygen Service, Atlanta, Georgia
- 31 Medics Pharmaceutical Corp., Decatur, Georgia
- 35 H. G. Fischer & Co., Powder Springs, Georgia
- 36 Wachtel's Physician Supply Co., Savannah
- 37 Hart Laboratories, Paoli, Penn.
- 43 Ga. Royal Crown Bottlers Assn., Augusta, Ga.
- 44 The Medequip Corp., East Point, Georgia
- 45 Eli Lilly & Company, Indianapolis, Ind.
- 46 W. B. Saunders, Co., Philadelphia, Penn.
- 47 Marks Surgical Supply Co., Augusta, Ga.
- 48 Merck Sharp & Dohme, West Point, Penn.
- 49 Knoll Pharmaceutical Company, Orange, N. J.
- 50 Warren-Teed Pharmaceutical, Inc., Columbus, Ohio

**Fifty Year Members**

Physicians who have practiced medicine for 50 years will be honored at the MAG Annual Session by the award of a 50-Year Pin and Certificate. These awards will be presented at the MAG final General Business Session on Tuesday afternoon, May 4 at 2:30 p.m. in the Embassy Room. The following list contains the names of the members of the Medical Association who, as of the year 1965, have practiced medicine for 50 years. It does not record the names of physicians who have already received gold membership cards. This includes only those members in the class of 1915 who were also licensed in Georgia in 1915 as follows:

Wayne Aiken . . . . .	Atlanta
James F. Arthur . . . . .	Atlanta
Robert M. Avery . . . . .	LaGrange
Stephen T. Brown . . . . .	Atlanta
Olin S. Cofer . . . . .	Atlanta
Horace E. Crow . . . . .	Oakwood
Crawford W. Dyer . . . . .	Macon
David H. Garrison . . . . .	Clarkesville
Walton A. Johnson . . . . .	Elberton
Marcus Mashburn . . . . .	Cumming
William W. Meriwether . . . . .	Macon
William A. Newman . . . . .	Macon
William Parks Phillips . . . . .	LaGrange
William T. Randolph . . . . .	Winder
Eugene F. Thompson . . . . .	Valdosta
John William Turner . . . . .	Atlanta
Lloyd L. Whitley . . . . .	Athens
Solomon S. Youmans . . . . .	Swainsboro

**CALL FOR SCIENTIFIC EXHIBITS**

**111TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA**

**Augusta, Georgia, May 2-4, 1965**

**For Information and Applications, Write to:**

**John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee**

**938 Peachtree Street, N.E. • Atlanta, Georgia 30309**

# MAG PROGRAM RESUME

## Sunday, May 2

- 2:00 P.M. Radiology, Chest and Public Health Joint Section Meeting, *Boxwood Room, Augusta Town House*
- 2:00 P.M. Anesthesiology, Ophthalmology & Otolaryngology and Surgery Joint Section Meeting, *Teakwood Room, Augusta Town House*
- 2:00 P.M. Dermatology, Pathology, General Practice and Internal Medicine Joint Section Meeting, *Embassy Room, Augusta Town House*
- 4:30 P.M. MAG General Business Session, *Embassy Room, Augusta Town House*
- 5:30 P.M. Delegates and Exhibitors Social Hour, *Poolside, Augusta Town House*

## Monday, May 3

- 9:00 A.M. MAG General Business Session and House of Delegates Meeting, *Embassy Room, Augusta Town House*
- 10:30 A.M. Pediatrics, Obstetrics & Gynecology and Diabetes Joint Section Meeting, *Embassy Room, Augusta Town House*

- 10:30 A.M. Psychiatry, General Practice and Orthopedics Joint Section Meeting, *Teakwood Room, Augusta Town House*
- 2:30 P.M. MAG Reference Committees No. 1, No. 2, No. 3, No. 4, and No. 5 Meetings, *Embassy Room, Augusta Town House*
- 6:30 P.M. Richmond County Social Hour, *Pool Patio, Augusta Town House*
- 8:00 P.M. MAG President's Banquet, *Embassy Room, Augusta Town House*

## Tuesday, May 4

- 9:00 A.M. Obstetrics & Gynecology, Internal Medicine and General Practice Joint Section Meeting, *Teakwood Room, Augusta Town House*
- 9:00 A.M. Pathology, Surgery, Urology and Radiology Joint Section Meeting, *Embassy Room, Augusta Town House*
- 12:00 NOON Abner W. Calhoun Memorial Lectureship, *Embassy Room, Augusta Town House*
- 2:30 P.M. MAG General Business Session and House of Delegates Second Meeting, *Embassy Room, Augusta Town House*

### REMINDER TO COUNTY SOCIETY SECRETARIES

Have your County Society membership dues been remitted to the MAG Headquarter's Office? Dues are payable January 1, and delinquent April 1.

# 1965 ANNUAL SESSION SECTION CHAIRMAN

#### ANESTHESIOLOGY

Zachariah W. Gramling, M.D.  
Talmadge Memorial Hospital  
Augusta

#### CHEST

David P. Hall, M.D.  
Medical College of Georgia  
Augusta

#### DERMATOLOGY

C. Conrad Smith, M.D.  
1349 Druid Park Avenue  
Augusta

#### DIABETES

Alex T. Murphy, M.D.  
1134 Druid Park Avenue  
Augusta

#### GENERAL PRACTICE

William A. Fuller, M.D.  
1403 Gwinnett Street  
Augusta

#### MEDICINE

Harry T. Harper, Jr., M.D.  
1467 Harper Street  
Augusta

#### OBSTETRICS AND GYNECOLOGY

C. I. Bryans, Jr., M.D.  
Talmadge Memorial Hospital  
Augusta

#### OPHTHALMOLOGY and OTOLARYNGOLOGY

John R. Fair, M.D.  
Medical College of Georgia  
Augusta

#### ORTHOPEDICS

Charles Freeman, M.D.  
1136 Druid Park Avenue  
Augusta

#### PATHOLOGY

Menard Ihnen, M.D.  
Laboratory, University Hospital  
Augusta

#### PEDIATRICS

A. Joe Green, M.D.  
1727 Central Avenue  
Augusta

#### PSYCHIATRY

Julius T. Johnson, M.D.  
1445 Harper Street  
Augusta

#### PUBLIC HEALTH

Abe J. Davis, M.D.  
3039 Pine Needle Road  
Augusta

#### RADIOLOGY

Stephen W. Brown, M.D.  
2922 Bransford Road  
Augusta

#### SURGERY

Harry D. Pinson, M.D.  
1467 Harper Street  
Augusta

#### UROLOGY

J. Robert Rinker, M.D.  
Medical College of Georgia  
Augusta



# THE PROGRAM

FRIDAY, APRIL 30

## Related Events

(Not a part of Official Program)

*NOTE: Make Reservations in Advance with Chairman if possible.*

- 1:00 Georgia Chapter, American Academy of Pediatrics Luncheon and Scientific Session  
*Holiday Inn*  
A. J. Green and P. D. Ellington, Augusta, Co-Chairmen
- 7:00 Georgia Chapter, American Academy of Pediatrics Social Hour  
*Holiday Inn*  
A. J. Green and P. D. Ellington, Augusta, Co-Chairmen

- 12:00 Georgia Society of Dermatologists Business Meeting and Luncheon  
*Augusta Town House*  
C. Conrad Smith, Augusta, Chairman
- 12:00 Georgia Medical Political Action Committee Luncheon  
(All Physicians Urged to Attend)
- 12:30 Georgia Thoracic Society and Georgia Chapter, American College of Chest Physicians Luncheon and Business Meeting  
*Augusta Town House*  
David P. Hall, Augusta, Chairman
- 1:00 Georgia Chapter, American Association of Public Health Physicians Business Meeting  
*Augusta Town House*  
Abe J. Davis, Augusta, Chairman

SATURDAY, MAY 1

## Related Events

(Not a part of Official Program)

*NOTE: Make Reservations in Advance with Chairman if possible.*

- 8:30 Georgia Chapter, American Academy of Pediatrics  
*Golf—Augusta Country Club*  
A. J. Green, Augusta, Chairman
- 1:30 Georgia Chapter, American Academy of Pediatrics Luncheon and Business Session  
*Holiday Inn*  
A. J. Green and P. D. Ellington, Augusta, Co-Chairmen
- 3:00 Georgia Society of Anesthesiologists Special Scientific Meeting  
*Georgian Room, Augusta Town House*  
Z. W. Gramling, Augusta, Chairman
- 6:30 Georgia Psychiatric Association Dinner  
*Elks Club, BPOE #205*  
Julius T. Johnson, Augusta, Chairman
- 8:00 Georgia Psychiatric Association Business Meeting  
*Elks Club, BPOE #205*  
Julius T. Johnson, Augusta, Chairman
- 7:00 Georgia Society of Dermatologists Social Hour and Dinner  
*Augusta Town House*  
C. Conrad Smith, Augusta, Chairman

SUNDAY, MAY 2

## Related Events

(Not a part of Official Program)

*NOTE: Make Reservations in Advance with Chairman if possible.*

- 9:00 Georgia Society of Anesthesiologists Business Meeting  
*Augusta Town House*  
Z. W. Gramling, Augusta, Chairman
- 11:30 Georgia Pediatric Society Luncheon and Business Meeting  
*Downtown Motor Inn, Augusta*  
A. Joe Green, Augusta, Chairman

SUNDAY AFTERNOON, MAY 2

## 2:00 Radiology, Chest and Public Health Joint Section Meeting

(ALL PHYSICIANS INVITED)

*Boxwood Room, Augusta Town House*

PRESIDING

Abe J. Davis, Augusta

## 2:00 EXPERIENCES WITH COAL WORKERS LUNG DISEASES

Donald L. Rasmussen, Beckley, West Virginia

## 2:30 PULMONARY COMPLICATIONS OF ACHALASIA

Colin B. Holman, Rochester, Minnesota

## 3:00 PREOPERATIVE RADIATION AND INCREASED RESECTABILITY IN BRONCHOGENIC CARCINOMA

Donald L. Paulson, Dallas, Texas

## 3:30 VIEW EXHIBITS

## 3:45 PANEL DISCUSSION

MODERATOR

David P. Hall, Augusta

PANEL

Donald L. Rasmussen, Beckley, West Virginia  
Colin Holman, Rochester, Minnesota  
Donald L. Paulson, Dallas, Texas

## 2:00 Anesthesiology, Ophthalmology & Otolaryngology and Surgery Joint Section Meeting

(ALL PHYSICIANS INVITED)

*Teakwood Room, Augusta Town House*

PRESIDING

Harry D. Pinson, Augusta

## 2:00 AIRWAY PROBLEMS IN HEAD AND NECK SURGERY

Daniel B. Sullivan, Augusta

## 2:20 REGIONAL ANESTHESIA IN HEAD AND NECK SURGERY

Leonard W. Fabian, Jackson, Mississippi

## 2:40 THE PREOPERATIVE USE OF INTRAVENOUS HYDROXYZINE (VISTARIL) IN INTRA-OCULAR SURGERY

John R. Fair, Augusta

## 3:00 INTRAVENOUS XYLOCAINE IN ENDOSCOPIC PROCEDURES

John S. Turner and John Steinhaus, Atlanta

- 3:30 **PANEL**  
**USE OF SEDATIVE DRUGS IN HEAD AND  
 NECK SURGERY WITH LOCAL OR REGIONAL  
 ANESTHESIA**  
**MODERATOR**  
 Perry P. Volpitto, Augusta
- PANEL**  
 Daniel B. Sullivan, Augusta  
 John R. Fair, Augusta  
 Leonard W. Fabian, Jackson, Mississippi  
 John S. Turner, Atlanta
- 2:00 **Dermatology, Pathology, General Practice  
 and Internal Medicine Joint Section Meet-  
 ing**  
 (ALL PHYSICIANS INVITED)  
*Embassy Room, Augusta Town House*  
**PRESIDING**  
 Harry T. Harper, Augusta
- 2:00 **HAIR: RECENT ADVANCES IN KNOWLEDGE**  
 Robert A. Berger, New York, New York
- 2:30 **CPC: VARICES, THROMBOSES, AND  
 PULMONARY EMBOLISM**  
**PANEL**  
 W. Frank McKemie, Albany  
 Robert M. Fine, Decatur  
 Louis L. Battey, Augusta  
 William H. Moretz, Augusta  
 A. B. Chandler, Augusta
- 4:30 **MAG General Business Session**  
 (ALL MAG AND AUXILIARY MEMBERS  
 AND GUESTS INVITED)  
*Embassy Room, Augusta Town House*  
**PRESIDING**  
 J. G. McDaniel, Atlanta, President  
 Medical Association of Georgia  
**NOMINATIONS OF OFFICERS AND  
 COUNCILORS**  
*(Announcement of Tellers Committee)*  
 President-Elect  
 Second Vice President  
 Speaker of the House (To serve until 1968)  
 Vice Speaker of the House (To serve until  
 1968)  
 Fifth District Councilor (To serve until  
 1968)  
 Fifth District Vice Councilor (To serve  
 until 1968)  
 Sixth District Councilor (To serve until  
 1968)  
 Sixth District Vice Councilor (To serve  
 until 1968)  
 Seventh District Councilor (To serve until  
 1968)  
 Seventh District Vice Councilor (To serve  
 until 1968)  
 Eighth District Councilor (To serve until  
 1968)  
 Eighth District Vice Councilor (To serve  
 until 1968)  
 Muscogee County Medical Society Coun-  
 cilor (To serve until 1968)  
 Muscogee County Medical Society Vice  
 Councilor (To serve until 1968)

- Fulton County Medical Society Councilor  
 (To serve until 1968)  
 Fulton County Medical Society Vice Coun-  
 cilor (To serve until 1968)  
 Fulton County Medical Society Vice Coun-  
 cilor (To serve until 1966)  
 AMA Delegate (Term beginning January  
 1, 1965)  
 AMA Alternate Delegate (Term beginning  
 January 1, 1965)  
 AMA Delegate (Term beginning January  
 1, 1966)  
 AMA Alternate Delegate (Term beginning  
 January 1, 1966)  
**Nominations for Awards:**  
 General Practitioner of the Year Award  
 (To be voted on by House of Delegates)

## SUNDAY EVENING, MAY 2

- 5:30 **DELEGATES AND EXHIBITORS SOCIAL HOUR**  
*Embassy Room, Augusta Town House*

## SUNDAY EVENING, MAY 2

### Related Events

(Not a part of Official Program)

*NOTE: Make Reservations in Advance with Chairman  
 if possible.*

- 6:30 Medical College of Georgia Alumni Social  
 Hour and Dinner  
*Augusta Town House*  
 6:30 Emory University Medical Alumni Associa-  
 tion Social Hour and Dinner  
 Walter E. Mingledorff, Augusta, Chairman

## MONDAY MORNING, MAY 3

### Related Events

(Not a part of Official Program)

*NOTE: Make Reservations in Advance with Chairman  
 if possible.*

- 9:20 Georgia Radiological Society—Demonstration  
 of Image Intensifiers  
*Department of Radiology, Medical College of  
 Georgia*  
 Stephen W. Brown, Augusta, Chairman  
 11:30 Georgia Radiological Society Business Meet-  
 ing and Luncheon  
*Augusta Town House*  
 Stephen W. Brown, Augusta, Chairman

## MONDAY MORNING, MAY 3

- 9:00 **MAG General Business Session and  
 House of Delegates Meeting**  
 (ALL MAG AND AUXILIARY MEMBERS  
 AND GUESTS INVITED)  
*Embassy Room, Augusta Town House*  
 8:45 **MAG DELEGATES REGISTRATION**  
*Embassy Room Entrance*  
 9:00 **GENERAL BUSINESS SESSION**  
**PRESIDING**  
 J. G. McDaniel, Atlanta, President  
 Medical Association of Georgia



## INVOCATION

Reverend Allen B. Clarkson, Rector  
Good Shepherd Episcopal Church, Augusta

## WELCOME

Cecil A. White, President  
Richmond County Medical Society

## GREETINGS

Honorable George A. Sanchen, Jr., Mayor  
City of Augusta

## OUR ASSOCIATION FUTURE FOR 1965-1966

George H. Alexander, Forsyth, President-Elect  
Medical Association of Georgia

## MAG MEMORIAL SERVICE

## HOUSE OF DELEGATES MEETING

### PRESIDING

J. Frank Walker, Atlanta, Speaker of the House

### ORDER OF BUSINESS (See Delegates Handbook)

### REPORT OF PRESIDENT WOMAN'S AUXILIARY TO MAG

Mrs. John T. Leslie, Avondale Estates

## MONDAY MORNING, MAY 3

### 10:30 Pediatrics, Obstetrics & Gynecology and Diabetes Joint Section Meeting

(ALL PHYSICIANS INVITED)

*Embassy Room, Augusta Town House*

#### PRESIDING

Alex T. Murphey, Augusta

### 10:30 THE CLINICAL MANAGEMENT OF DIABETES IN PREGNANCY—THE OBSTETRICAL ASPECTS

Richard Burt, Winston-Salem, North Carolina

### 11:00 THE CLINICAL MANAGEMENT OF DIABETES IN PREGNANCY—THE MEDICAL ASPECTS

Priscilla White, Boston, Massachusetts

### 11:30 THE CLINICAL MANAGEMENT OF DIABETES IN PREGNANCY—THE PEDIATRIC ASPECTS

Gerald Holman, Augusta

### 12:00 PANEL

#### MODERATOR

John Buse, Charleston, South Carolina

#### PANEL

Richard Burt, Winston-Salem, North Carolina

Priscilla White, Boston, Massachusetts

Gerald Holman, Augusta

Alex T. Murphey, Augusta

### 10:30 Psychiatry, General Practice and Orthopedics Joint Section Meeting

(ALL PHYSICIANS INVITED)

*Boxwood Room, Augusta Town House*

#### PRESIDING

Charles Freeman, Augusta

### 10:30 RECENT CONCEPTIONS OF DEPRESSION

Marion B. Richmond, Kensington, Maryland

### 11:00 THE CONGENITALLY DEFORMED HAND

Frank H. Stelling, Greenville, South Carolina

### 11:30 ALCOHOLISM—A COMMUNITY PROBLEM, A MEDICAL RESPONSIBILITY

A. John Mooney, Statesboro

### 12:00 PANEL DISCUSSION

#### MODERATOR

Charles Freeman, Augusta

#### PANEL

Marion B. Richmond, Kensington, Maryland

Frank H. Stelling, Greenville, South Carolina

A. John Mooney, Statesboro

## MONDAY AFTERNOON, MAY 3

### Related Events

(Not a part of Official Program)

*NOTE: Make Reservations in Advance with Chairman if possible.*

1:00 Georgia Diabetes Association Luncheon  
*Augusta Town House*

Alex T. Murphey, Augusta, Chairman

2:00 Georgia Diabetes Association Business Meeting  
*Augusta Town House*

Alex T. Murphey, Augusta, Chairman

2:00 Georgia Radiological Society Scientific Session  
*Augusta Town House*

### 2:30 MAG REFERENCE COMMITTEES

Reference Committees No. 1, No. 2, No. 3,  
No. 4 and No. 5

*Embassy Room, Augusta Town House*

## MONDAY EVENING, MAY 3

### 6:30 RICHMOND COUNTY SOCIAL HOUR

Sponsored by Trust Company of Georgia,  
Atlanta, and affiliated banks:

Augusta—First National Bank and Trust  
Company

Columbus—Fourth National Bank

Macon—First National Bank and Trust  
Company

North Atlanta—DeKalb National Bank  
of Brookhaven

Rome—First National Bank

Savannah—Liberty National Bank and  
Trust Company

*Poolside, Augusta Town House*

### 8:00 MAG PRESIDENT'S BANQUET

*Embassy Room, Augusta Town House*

## TUESDAY MORNING, MAY 4

### 9:00 Obstetrics & Gynecology, Internal Medicine and General Practice Joint Section Meeting

(ALL PHYSICIANS INVITED)

*Teakwood Room, Augusta Town House*

#### PRESIDING

Frederick P. Zuspan, Augusta

### 9:00 INTRODUCTION TO TOXEMIAS OF PREGNANCY

Michael Newton, Jackson, Mississippi

### 9:30 CLINICAL HEMODYNAMICS AND PHARMACODYNAMICS OF TOXEMIA

Frank A. Finnerty, Jr., Washington, D. C.

### 10:15 RELATIONSHIP OF DIABETES TO TOXEMIAS OF PREGNANCY

Priscilla White, Boston, Massachusetts

### 10:30 VIEW EXHIBITS

### 11:00 PANEL ON TOXEMIAS OF PREGNANCY

#### MODERATOR

C. I. Bryans, Augusta

#### PANEL

Michael Newton, Jackson, Mississippi

Frank A. Finnerty, Jr., Washington, D. C.

Priscilla White, Boston, Massachusetts

E. J. Dennis, Charleston, South Carolina

**9:00 Pathology, Surgery, Urology & Radiology  
Joint Section Meeting**

(ALL PHYSICIANS INVITED)

*Embassy Room, Augusta Town House*

PRESIDING

(To be announced)

INSTRUCTIVE CASE REPORTS FROM THE  
FOLLOWING CATEGORIES WILL BE PRE-  
SENTED WITH PERTINENT CLINICAL  
COURSE, X-RAYS, LABORATORY TESTS,  
ETC.:

**9:00 POSTOPERATIVE DEATHS**

MODERATOR

Menard Ihnen, Augusta

PANEL

(To be announced)

**10:00 TRAUMA**

MODERATOR

Harold Engler, Augusta

PANEL

(To be announced)

**11:00 CANCER**

MODERATOR

S. W. Brown, Augusta

PANEL

(To be announced)

**TUESDAY, MAY 4**

**12:00 Abner W. Calhoun Memorial Lectureship**

(ALL PHYSICIANS INVITED)

*Embassy Room, Augusta Town House*

PRESIDING

J. G. McDaniel, Atlanta, President  
Medical Association of Georgia

**12:00 THE GOLD-HEADED CANE: THE MEN, THE  
BOOKS, THE TRADITION**

William B. Bean, Iowa City, Iowa

**TUESDAY AFTERNOON, MAY 4**

**Related Events**

(Not a part of Official Program)

*NOTE: Make Reservations in Advance with Chairman  
if possible.*

**12:15 Georgia Urological Association Luncheon  
and Business Meeting**

*Augusta Town House*

J. Robert Rinker, Augusta, Chairman

**2:30 MAG General Business Session and  
House of Delegates Second Meeting**

(ALL MAG AND AUXILIARY MEMBERS  
AND GUESTS INVITED)

*Embassy Room, Augusta Town House*

**2:15 MAG DELEGATES REGISTRATION**

*Embassy Room Entrance*

**2:30 HOUSE OF DELEGATES SECOND MEETING**

PRESIDING

J. Frank Walker, Atlanta, Speaker of the House

ORDER OF BUSINESS

(See Delegates Handbook)

ADJOURNMENT OF THE HOUSE

GENERAL BUSINESS SESSION

PRESIDING

J. G. McDaniel, Atlanta, President  
Medical Association of Georgia

PRESENTATION OF 50 YEAR CERTIFICATES

George R. Dillinger, Thomasville, Immediate  
Past President, Medical Association of  
Georgia

PRESENTATION OF SCIENTIFIC EXHIBIT  
AWARDS

John N. McClure, Atlanta, Chairman  
Scientific Awards Committee

PRESENTATION OF GENERAL PRACTITIONER  
OF THE YEAR AWARD

J. Hubert Milford, Hartwell, President  
Georgia Academy of General Practice

PRESENTATION OF MAG CERTIFICATES OF  
APPRECIATION

John T. Mauldin, Atlanta, Secretary  
Medical Association of Georgia

PRESENTATION OF HARDMAN AWARD

George H. Alexander, Forsyth, President-Elect  
Medical Association of Georgia

PRESENTATION OF MAG DISTINGUISHED  
SERVICE AWARD

J. G. McDaniel, Atlanta, President  
Medical Association of Georgia

SELECTION OF SITE FOR MAG 1967  
ANNUAL MEETING

ANNOUNCEMENT OF MAG ELECTION  
RESULTS

Chairman, Tellers Committee

INSTALLATION OF 1965-1966 OFFICERS

J. G. McDaniel, Atlanta, Immediate Past  
President, Medical Association of Georgia

ADJOURNMENT OF 111TH ANNUAL SESSION

**VOTING RULES**

**Bylaws, Chapter V, Election of Officers**

BYLAWS, CHAPTER V, ELECTION OF OFFICERS  
SECTION 3, METHOD. The President shall appoint a  
committee of not less than three Tellers immediately  
after the close of nominations, who shall have charge  
of the election. The Secretary shall have prepared in  
advance an official ballot and an official ballot box,  
which shall be kept in the custody of the Tellers  
Committee. One ballot only shall be given to each  
active voting member when he presents himself to  
cast his ballot. Each member and no other shall pre-

pare his ballot and shall deposit it at that time in the  
locked ballot box.

The candidates for office receiving a majority of  
the votes shall be declared elected, but if no majority  
is received on the first ballot, the members present  
shall select by secret ballot the officer from the two  
candidates having the highest number of votes.

SECTION 4. TIME. Voting shall take place during the  
hours of the scientific program up to the beginning  
of the last day of the Annual Session. At that time  
the Committee of Tellers shall count the ballots and  
report their findings to the members.



# GUEST SPEAKERS

## DONALD L. RASMUSSEN, M.D.

Beckley, West Virginia

DONALD L. RASMUSSEN, M.D., Chief Medical Officer, Appalachian Coal Miners Research Unit, Beckley Appalachian Regional Hospital, Beckley, West Virginia, is a graduate of the University of Utah College of Medicine. He served internships as a Research Fellow at the University of Utah, and in Internal Medicine at the University of Minnesota, and was a medical resident at the University of Utah and Veterans Administration Hospitals.

Dr. Rasmussen will speak to the Radiology, Chest and Public Health Joint Section Meeting on Sunday, May 2 at 2:00 P.M. The summary of his paper, "Experiences With Coal Workers Lung Diseases," follows:

Studies of cardiopulmonary function among bituminous coal miners in the Appalachian region have demonstrated considerable disability which is poorly related to ventilatory impairment. The finding of right ventricular hypertrophy is quite common and is unrelated to either ventilatory disturbances or to anoxemia. There is in general, a poor correlation between the x-ray category and the degree of impairment.

## COLIN B. HOLMAN, M.D.

Rochester, Minnesota

COLIN B. HOLMAN, M.D., Mayo Clinic, Rochester, Minnesota, will present his paper, "Pulmonary Complications of Achalasia," to the Joint Section Meeting of Radiology, Chest and Public Health on Sunday, May 2 at 2:30 P.M.

Dr. Holman is a graduate of Dartmouth College and received his medical degree from the University of Pennsylvania Medical School. He interned at King County Hospital, Seattle, Washington, and was a Radiology Fellow at the Mayo Graduate School of Medicine. He is at present a Consultant in Diagnostic Roentgenology at the Mayo Clinic, and Associate Professor of Radiology at the Mayo Graduate School of Medicine.

Following is a summary of Dr. Holman's presentation.

Records of more than 1,000 patients with achalasia seen at the Mayo Clinic in a period of more than 20 years were reviewed to determine the type and incidence of significant pulmonary complications associated with this disease. These complications proved to be aspiration pneumonitis, bronchiectasis, pulmonary abscess, asthma and emphysema, and aspiration pneumonitis was the most common. The amount of pulmonary tissue involved varied considerably from a small localized region to a diffuse bilateral process. The suggestive roentgenographic appearance of such lesions is described.

Pulmonary fibrosis following aspiration pneumonitis was noted in some cases. The symptoms of certain independent pulmonary disease processes appeared to abate after treatment of the coexistent achalasia. Since this disease can be managed effectively and since relatively many pulmonary complications are associated with it, the value of alertness to evidence of achalasia is apparent.

## DONALD L. PAULSON, M.D.

Dallas, Texas

DONALD L. PAULSON, M.D., Dallas, Texas, is Chief, Section of Thoracic Surgery, Baylor University Center, Dallas. He received his medical degree from the University of Minnesota, Minneapolis, and did post-graduate work there and at the Mayo Foundation and Mayo Clinic, Rochester. Dr. Paulson has been in private practice in thoracic surgery in Dallas since 1946 and is presently Consultant in Thoracic Surgery at Parkland Memorial and Woodlawn Hospitals, Children's Medical Center, McKnight State Tuberculosis Hospital, the VA Hospital and St. Paul Hospital, Dallas.

He is a Fellow of the American College of Surgeons, and a member of the American Association for Thoracic Surgery and of the Advisory Editorial Board of the *Journal of Thoracic and Cardiovascular Surgery*, and a member of the Board of Thoracic Surgery.

Dr. Paulson will present his paper, "Preoperative Radiation and Increased Resectability in Bronchogenic Carcinoma," to the Radiology, Chest and Public Health Joint Section Meeting on Sunday, May 2 at 3:00 P.M. A precis follows:

Presurgical irradiation in moderate dosage has converted superior sulcus tumors to operable lesions with prolonged survival in some cases. Previous experience was poor whether the patient received no treatment, irradiation alone or resection followed by irradiation.

Bronchogenic carcinomas developing peripherally in the upper lobe of either lung and invading the superior sulcus of the chest (Pancoast tumor) are usually low grade epidermoid carcinomas which grow slowly and metastasize late. Situated in the narrow confines of the apex of the chest, they invade early the lymphatics in the endothoracic fascia, involve the lower roots of the brachial plexus, the intercostal nerves, the stellate ganglion, the sympathetic chain, adjacent ribs and vertebrae producing severe pain and the Horner's syndrome. Generally such tumors have been considered as not accessible to complete surgical removal and to resist all efforts at irradiation treatment. Average expected time of survival reported in the literature has been 10 to 14 months.

Since 1956, 43 patients with tumors in the superior sulcus have been treated by means of presurgical irradiation. Twenty-six patients underwent combined presurgical irradiation and radical resection over two years ago. Of these, nine patients are alive and well two to eight years later including five over five years. One patient has survived eight years; one at seven years; three at five years; two at four years; one at three years and one at two years. Although previous experience does not constitute a strict control, the results would appear to be significant in the conversion of an inoperable lesion in this location to a respectable one with prolonged survival.

## LEONARD W. FABIAN, M.D.

Jackson, Mississippi

LEONARD W. FABIAN, M.D., is Professor of Anesthesiology and Chairman of the department at The



University of Mississippi School of Medicine where he also holds an appointment as associate professor of pharmacology.

Dr. Fabian is active in anesthesiology research and is co-inventor of a precision vaporizer for fluothane, developed when he was at Duke University. He has continued his work in this field at the University Medical Center in Jackson.

Dr. Fabian is a 1951 graduate of the University of Arkansas Hospital and held a fellowship at Philadelphia Children's Hospital in 1954.

He was an instructor in anesthesiology at Arkansas from 1954 to 1955, when he went to Duke as an Assistant Professor. He was named to his present post in 1958.

Dr. Fabian is a Fellow of the American College of Anesthesiologists, a Diplomate of the American Board of Anesthesiology, a member of the American Society of Anesthesiologists, and the International Anesthesia Research Society. Currently serving a six-year term on the board of governors of the American College of Anesthesiologists, Dr. Fabian is Associate Editor of both *Clinical Anesthesia* and *International Anesthesiology Clinics*.

Dr. Fabian will speak to the Anesthesiology, Ophthalmology and Surgery Joint Section Meeting, Sunday, May 2 at 2:20 P.M. A summary of his presentation, "Regional Anesthesia in Head and Neck Surgery" follows:

The discussion of this topic will include the utilization of various types of local and regional blocks for head and neck surgery and a brief discussion of the possible complications of local and regional anesthesia in this area. Although regional anesthesia is generally considered the safest form of anesthesia, there are a number of hazards associated with this type of anesthesia, particularly when the anesthetist is not quite familiar with the pharmacology of the individual drugs employed. This is particularly true in the case of overdosage with these various drugs. The problem of toxicity and the management of such complications will be discussed.

## ROBERT A. BERGER, M.D.

New York, New York

ROBERT A. BERGER, M.D., New York, New York, is a graduate of the New York City School of Medicine. He interned at Montefiore Hospital, New York City, and served a residency in dermatology at Bellevue Hospital, New York. He is presently engaged in the private practice of dermatology, and is Clinical Assistant Dermatologist at Mt. Sinai Hospital, New York. He is a Fellow of the American Academy of Dermatology and a Diplomate of the American Board of Dermatology and Syphilology and of the National Board of Medical Examiners.

Dr. Berger will present his paper at 2:00 P.M. Sunday, May 2 to the Joint Section Meeting of Dermatology, Pathology, General Practice and Internal Medicine.

A brief precis of his paper, "Hair: Recent Advances and Knowledge," follows:

The human hair follicle represents one of the most dynamic and metabolically active organ systems of the

body. Recent advances in our knowledge of the anatomy and physiology of the follicular apparatus will be reviewed, and the remarkable cyclic nature of normal hair growth analyzed.

Recent work on pathological responses of the hair follicle in various disease states will be discussed. The nature of follicular damage due to a variety of medications will be presented. Finally, newer knowledge in the therapeutics of common hair loss states will be reviewed.

## RICHARD L. BURT, M.D.

Winston-Salem, North Carolina

RICHARD L. BURT, M.D., Professor, Department of Obstetrics and Gynecology, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, North Carolina, is the Director of the Section on Reproductive Biology. Dr. Burt is a graduate of Brown University and Harvard Medical School. He served his internship at the U.S. Naval Hospital, Chelsea, Massachusetts, and his residency at North Carolina Baptist Hospital, Winston-Salem. He has held fellowships at Brown University and Harvard School of Dental Medicine. He is a member of the American Association for the Advancement of Science, the American College of Obstetricians and Gynecologists, and the American Diabetes Association. He is a Diplomate of the American Board of Obstetrics and Gynecology.

Dr. Burt will present his paper, "Obstetrical Aspects of Diabetes," on Monday, May 3 at 10:30 A.M. A summary follows:

Although diabetes mellitus has been recognized clinically for 19 centuries, until the advent of insulin this disease rarely occurred as a complication of pregnancy. Fetal and maternal mortality were extremely high in the pre-insulin era and amenorrhea, infertility, and abortion common. Although insulin made pregnancy permissible, obstetrical problems still occur despite satisfactory metabolic control. In the reported literature acute toxemia, polyhydramnios, fetal anomalies and fetal wastage are increased significantly above the figures for the nondiabetic. In addition, the metabolic error of the diabetic patient is increased as resistance to exogenous insulin normally develops during the latter half of pregnancy. Because successful pregnancy outcome is directly related to the degree of metabolic control, close prenatal supervision on a weekly basis is required with appropriate attention to diabetic regulation and prompt correction of ketosis should it occur. Abrupt changes in regulation occur with infection, particularly of the urinary tract which may be asymptomatic in pregnancy. Clinical criteria of control are first, freedom from symptoms referable to the diabetes; second, maintenance of weight or normal allowable weight gain; and third, absence of ketosis. At the 32nd week brief hospitalization is desirable for assessment of regulation. Late intrauterine death is avoided by premature delivery in the 37th week. Should conditions not be favorable for induction, or should attempted induction fail, abdominal delivery under conduction anesthesia is carried out. During labor or surgery, hydration is maintained by parenteral glucose covered with regular insulin and ketosis is assiduously avoided. The use of sedation or analgesic drugs is minimized. The newborn infant is maintained in the premature nursery and expert pediatric consultation should be available.



## PRISCILLA WHITE, M.D.

Boston, Massachusetts

PRISCILLA WHITE, M.D., Boston Massachusetts, received her medical degree from Tufts University Medical School. She is on the staffs of the Joslin Clinic, New England Deaconess Hospital, Faulkner Hospital, and the Boston Lying-In Hospital, and is Consultant at the Boston Floating Hospital, New England Hospital, and the Children's Medical Clinic of the Boston Dispensary. Dr. White holds the position of Assistant Professor of Pediatrics, Tufts University Medical School. She is a member of the American Diabetes Association, and an honorary member of the Royal Belgian Society of Obstetrics and Gynecology.

Dr. White delivered the 1960 Banting Memorial Lecture, American Diabetes Association, and was awarded the Banting Medal, the highest scientific recognition that organization can offer. She was the first woman invited to give the Banting Lecture; in addition, she was elected to the Council of the Association, the first woman to be elected to that office. In the summer of 1964 she was the representative speaker for the American Medical Women's Association at the meeting of the Medical Women's International Association held in Sandefjord, Norway.

Dr. White will present two papers to the 111th Annual Session. The first will be "The Clinical Management of Diabetes in Pregnancy—The Pediatric Aspects," on Monday, May 3 at 11:00 A.M. to the Pediatrics, Obstetrics and Gynecology, and Diabetes Joint Section Meeting; and the second, "Relationship of Diabetes To Toxemias of Pregnancy," will be presented at 10:15 A.M., Tuesday, May 4, to the Joint Section Meeting of Obstetrics and Gynecology, Internal Medicine and General Practice.

## JOHN BUSE, M.D.

Charleston, South Carolina

JOHN BUSE, M.D., Charleston, South Carolina, will moderate a panel on Monday, May 3 at 12:00 Noon for the Pediatric, Obstetrics and Gynecology, and Diabetes Joint Section Meeting.

Dr. Buse is a graduate of the Medical College of South Carolina, Charleston, and served an internship at the Roper Hospital, Charleston. He was an Assistant Medical Resident at both Roper and the University of Virginia; a Teaching Fellow and Chief Resident at the Medical College of South Carolina and Roper; and a Fellow in Medicine at the Cox Institute, Hospital of the University of Pennsylvania. He is presently Assistant Professor of Medicine, Medical College of South Carolina. He is a member of the American College of Physicians, the American Federation for Clinical Research, and the American Society of Internal Medicine.

## MARION B. RICHMOND M.D.

Kensington, Maryland

MARION B. RICHMOND, M.D., Kensington, Maryland, is currently Clinical Professor of Psychiatry at Georgetown University, a training analyst in the Washington Psychoanalytic Institute, and a Consultant to the National Institute of Mental Health.

Dr. Richmond earned his medical degree at the University of Maryland School of Medicine and trained in neurology and psychiatry in the United States Public Health Service and at George Washington University. He later graduated from the Washington School of Psychiatry and the Washington Psychoanalytic Institute. Before assuming his present positions he was in private practice for 16 years in Dallas, Texas.

Dr. Richmond will speak to the Psychiatry, General Practice and Orthopedics Joint Section Meeting on Monday, May 3 at 10:30 A.M. An abstract of his presentation, "Recent Conceptions of Depression," follows:

The presentation will reconsider well-known descriptive and dynamic formulations of depression in the light of recent endocrine studies. Attention will be given to a hypothetical state, ultimate psychic pain, against which depression defends, yet to which it contributes because of its own stress production. The relationship of depression to other mental illness, and to chronic disease, will be considered.

## FRANK H. STELLING, M.D.

Greenville, South Carolina

FRANK H. STELLING, M.D., Greenville, South Carolina, is a graduate of the Medical College of Georgia, Augusta. He interned, and served a residency in Pathology and Roentgenology at the University Hospital, Augusta. He also served residencies in orthopedics at Galliger Municipal Hospital, Washington, D.C., and the Children's Medical Center and Peter Bent Brigham Hospital, Boston. He is presently in private practice, and Chief Surgeon, Shriner's Hospital, Greenville; and Instructor in Orthopedic Surgery, Duke University School of Medicine, Durham, North Carolina. Dr. Stelling is a member of the Southeastern Surgical Congress, the American Academy of Orthopedic Surgery and the American Society for Surgery of the Hand.

His paper, "The Congenitally Deformed Hand," will be given before the Psychiatry, General Practice and Orthopedics Joint Section Meeting on Monday, May 3 at 11:00 A.M.

Following is a precis:

I shall present many types of congenital anomalies of the hand with special regard as to the care and treatment of these without going into the hereditary and genetic factors which, of course, are interesting but will not be covered in this session. The subject will consider problem cases more than the several common types of anomalies whose treatment is fairly standard. The subject will be presented in such manner that we will not go into the complicated details of surgery but mostly the types of deformities, what can and cannot be done, considering functional aspects primarily with the ideas of cosmetics that can be added without sacrifice of function. The subject will be presented with the aid of slides and moving pictures.

## MICHAEL NEWTON, M.D.

Jackson, Mississippi

MICHAEL NEWTON, M.D., Jackson, Mississippi, was born in England and received his early education there, including the first two years of medical school at Cambridge University. He was awarded a Rockefeller Foundation Scholarship to complete medical school at the



University of Pennsylvania, graduating M.D. in 1943. Following graduation he interned at the Pennsylvania Hospital in Philadelphia and subsequently spent two years doing casualty work in England. He then returned to this country where he received training in Physiology, Surgery and Obstetrics and Gynecology, at the University of Pennsylvania School of Medicine and the Hospital of the University of Pennsylvania. In 1954-55 he was in private practice in Obstetrics and Gynecology in Philadelphia, on the teaching staff of the Hospital of the University of Pennsylvania and on the staffs of the Bryn Mawr and Chester County Hospitals. Since 1955 he has been Professor and Chairman of the Department of Obstetrics and Gynecology at the University of Mississippi School of Medicine in Jackson, Mississippi.

Dr. Newton is a Diplomate of the American Board of Surgery and the American Board of Obstetrics and Gynecology. He is a Fellow of the American College of Surgeons, the American College of Obstetricians and Gynecologists, the American Society for the Study of Sterility and the Central Association of Obstetricians and Gynecologists.

Dr. Newton's paper, "Introduction to Toxemias of Pregnancy," will be presented to the Obstetrics and Gynecology, Internal Medicine and General Practice Joint Section Meeting on Tuesday, May 4 at 9:00 A.M.

## FRANK A. FINNERTY, M.D.

Washington, D.C.

FRANK A. FINNERTY, JR., M.D., Washington, D.C., is a graduate of the Georgetown University School of Medicine. From 1957-1962 he was an established investigator for the American Heart Association. He is presently Clinical Associate Professor of Medicine, Georgetown University Medical Center; and Chief, Cardiovascular Research, Georgetown University Medical Division, D.C. General Hospital. He is a member of the American Board of Internal Medicine, a Fellow of the American College of Physicians, and on the Council of High Blood Pressure Research, American Heart Association.

A summary of Dr. Finnerty's presentation, "Clinical Hemodynamics and Pharmacodynamics of Toxemia," which will be presented Tuesday, May 4 at 9:30 A.M. to the Obstetrics and Gynecology, Internal Medicine, and General Practice Joint Section Meeting follows:

For many years, toxemia has served as a wastebasket for a variety of disease states characterized by an elevated arterial pressure, edema, and albuminuria. This triad is consistent with the diagnosis of toxemia, but it is not diagnostic. These abnormalities may also be found in pregnant patients with hypertensive vascular disease, pyelonephritis, glomerulonephritis, or any combination of these. During the past 13 years, our group has attempted to differentiate elevated arterial pressure, albuminuria, and edema into separate and distinct diagnostic pieces. Ophthalmoscopic examination and urinalysis have been of great assistance in this regard.

All the signs and symptoms of toxemia may be adequately explained by abnormal sodium retention and generalized vasoconstriction. Clinical observation attests that sodium retention usually precedes generalized vasoconstriction, and prompt therapy of sodium retention usually prevents generalized vasoconstriction.

Vasoconstriction explains the remainder of the abnormality. An increase in cerebral vasoconstriction causes cerebral ischemia and leads to coma and convulsions. Cerebral ischemia, rather than the rise in arterial pressure, is the important abnormality in inducing coma and convulsions.

Evidence of both sodium retention and vasoconstriction, the two pathophysiological abnormalities, can be visualized ophthalmoscopically. A wet, glistening appearance of the entire retina (retinal sheen) and a decrease in the caliber of the retinal arteries characterized toxemia. The observation that generalized sheen of toxemia is promptly decreased following diuretic therapy strongly suggests that it represents retinal edema.

Increased constriction of the peripheral vessels seems to account for the elevated arterial pressure. The increase in arterial pressure in toxemia is not associated with a change in the cardiac output. Finally, the increased vasoconstriction in the renal circulation, particularly in the afferent vessels as noted by Assali accounts, in part at least, for the decrease in urinary output.

The availability of the thiazides has completely changed the concept of the treatment of toxemia. Prior to their development, the primary aim of therapy of toxemia was directed toward the control of arterial pressure and albuminuria (manifestations of generalized vasoconstriction). Reserpine, hydralazine, and veratrum, therefore, were used extensively in our clinic as well as in others. If the arterial pressure could not be lowered sufficiently, additional antihypertensive agents were added.

The primary aim of therapy of toxemia, at present, is prompt control of sodium retention. The effectiveness of the thiazides in the immediate control of abnormal sodium retention and the return of the plasma volume to normal has frequently prevented the development of generalized vasoconstriction, thereby eliminating the need of other antihypertensive therapy. When used alone at the first sign of excessive weight gain, the thiazides frequently reverse the toxemic process. Even more important is the observation that they can be administered continuously without the development of drug resistance, thus preventing the development of vasoconstriction. For practical purposes, the prevention of vasoconstriction is equivalent to the prevention of toxemia. In our experience, these diuretic agents have resulted in more than a 70 per cent reduction in the number of patients with toxemia during the past two years.

## EDWARD J. DENNIS, M.D.

Charleston, South Carolina

EDWARD J. DENNIS, M.D., Charleston, South Carolina, will be a panel member at the Joint Section Meeting of Obstetrics and Gynecology, Internal Medicine and General Practice, Tuesday, May 4 at 11:00 A.M.

Dr. Dennis is a graduate of the Medical College of South Carolina, Charleston, and served an internship at the Jersey City Medical Center. He served a residency and instructorship, and was an Associate and Assistant Professor, in Obstetrics and Gynecology, at the Roper Hospital, Charleston. He is presently Associate Professor of Obstetrics and Gynecology of the Medical College of South Carolina, Charleston. He is certified by the American Board of Obstetrics and Gynecology, and is a member of the American College of Obstetricians and Gynecologists, and the American Society for the Study of Sterility.



# WILLIAM B. BEAN, M.D.

Iowa City, Iowa

The 111th MAG Annual Session Abner W. Calhoun Memorial Lectureship will this year be presented by WILLIAM B. BEAN, M.D., Professor of Medicine and Head of the Department of Internal Medicine at the State University of Iowa College of Medicine, Iowa City, Iowa.

Dr. Bean is a graduate of the University of Virginia, and served his internship at Johns Hopkins Hospital. In 1944 he received the John Horsley Memorial Prize at the University of Virginia.

Dr. Bean was Assistant Resident Physician at the Boston City Hospital, Teaching Fellow at the Thorndike Memorial Laboratory in Boston, and Teaching Fellow in Medicine at Harvard University. At the Cincinnati General Hospital he was Senior Medical Resident, Assistant Attending Physician, Clinician in the Out-Patient Department, and Attending Physician. At the Cincinnati Medical College he was Instructor in Medicine, Fellow in Nutrition, Assistant Professor of Medicine, and Associate Professor of Medicine.

The following are societies in which Dr. Bean is a member: American Society for Clinical Investigation, Fellow of the American College of Physicians, World Medical Association, Association of American Physicians, and the American Association of the History of Medicine. Dr. Bean is also a Diplomat of the Ameri-

can Board of Internal Medicine. He was Councilor and President of the Central Society for Clinical Research and Councilor for the American Society for Clinical Investigation.

He is currently Chief Editor of the American Medical Association's *Archives of Internal Medicine*.

The Lecture, which will be presented at 12:00 Noon, Tuesday, May 4, will be entitled, "The Gold-Headed Cane: The Men, The Books, The Tradition." A precis follows:

The paper that I am planning to present deals with the Gold-Headed Cane, which was a symbol of medical supremacy in Britain in the 17th, 18th and 19th centuries. It was originally owned by John Radcliffe who obtained it apparently in 1689. He in turn passed it on to Richard Mead and it went then in turn to Askew, the Pitcairns, and finally Mathew Baillie, the nephew of John and William Hunter. The cane was immortalized in William McMichael's book entitled, "The Gold-Headed Cane," written as though it were an autobiography of the cane itself describing its various owners. This book was printed in England first in 1827. There have been six subsequent editions, the latest one being one brought out by Bill Kerr and Jim Waring published by Charles Thomas and Sons in 1953. The talk will encompass three matters. 1. Medicine as practiced by the owners of the Gold-Headed Cane, 2. The cane as a symbol of medical excellence, and 3. An analysis of the seven editions of the book over a period of roughly 125 years as an expression of artistry, technology, and bookmaking, representing as it does a state of culture, taste, and technology.

## 1965 CALENDAR OF MEETINGS

### State

- March 31-April 2—"Problems in Gastroenterology," sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.
- April 1-3—Annual Meeting of the Georgia Society of Ophthalmology and Otolaryngology, Callaway Gardens, Pine Mountain, Ga.
- April 3-4—Joint Meeting of the Atlanta Society of Pathologists, and the Gulf Region, College of American Pathologists, Academy of Medicine, Atlanta.
- April 8—Symposium on Cardiovascular Diseases, cosponsored by the Third District Medical Society and Lederle Laboratories, Ralston Motor Hotel, Columbus.
- April 23-24—Southeastern Section of the Association for Research in Ophthalmology, Emory University, Atlanta.
- April 23-24—Postgraduate Courses in "Radioisotope Scanning in Clinical Practice," sponsored by the Department of Radiology, Division of Nuclear Medicine, of Emory University School of Medicine, Grady Memorial Hospital, Atlanta.
- May 1-2—Lung Disease Seminar, Educational Building of the Medical College of Georgia, Augusta.
- May 2-4—111th Annual Session of the Medical Association of Georgia, Augusta.

### Regional

- March 22-24—Dallas Southern Clinical Society, Statler-Hilton Hotel, Dallas.
- March 23-26—National Society for Prevention of Blindness, Rice Hotel, Houston.
- March 25-27—Mid-Central States Orthopaedic Society, Velda Rose Motel, Hot Springs, Ark.
- March 26-27—National Conference on Rural Health (18th), Americana Hotel, Miami Beach.
- March 29-31—American Association for Thoracic Surgery, Roosevelt Hotel, New Orleans.
- April 5-8—Thirty-eighth Annual Spring Congress in Ophthalmology, Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va.

- April 11-14—Tennessee Medical Association, Reed House Hotel, Chattanooga, Tenn.
- April 22-24—Medical Association of the State of Alabama, Birmingham, Ala.
- April 26-29—American Academy of Pediatrics, Americana Hotel, Bal Harbour, Fla.
- April 28-May 1—West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, W. Va.
- May 1-5—Medical Society of the State of North Carolina, Queen Charlotte Hotel, Charlotte, N. C.
- May 2-5—American Association of Plastic Surgeons, Boca Raton Hotel, Boca Raton, Fla.
- May 9-13—American Urological Association, Roosevelt Hotel, New Orleans.
- May 10-13—Mississippi State Medical Association, Biloxi, Miss.
- May 14-15—Louisiana-Mississippi Ophthalmological and Otolaryngological Society, Edgewater Gulf Hotel, Biloxi, Miss.
- May 27-29—American Ophthalmological Society, Homestead Hotel, Hot Springs, Va.
- June 16-19—Society of Nuclear Medicine, Americana Hotel, Bal Harbour, Fla.
- June 28-July 1—American Orthopaedic Association, Hot Springs, Va.

### National

- April 4-8—13th Annual Clinical Meeting of the American College of Obstetrics and Gynecology, San Francisco.
- April 9-15—American Academy of General Practice, San Francisco.
- May 24-28—A Five Day Refresher Course in Pediatrics sponsored by the Children's Hospital of Philadelphia and the Department of Pediatrics, School of Medicine, University of Pennsylvania, Philadelphia, Pa.
- June 16—American Cancer Society, 1965 Scientific Session, Drake Hotel, Philadelphia, Pa.
- June 20-24, 1965—American Medical Association, Americana Hotel, New York City.



# **MEDICAL ASSOCIATION OF GEORGIA OFFICERS**

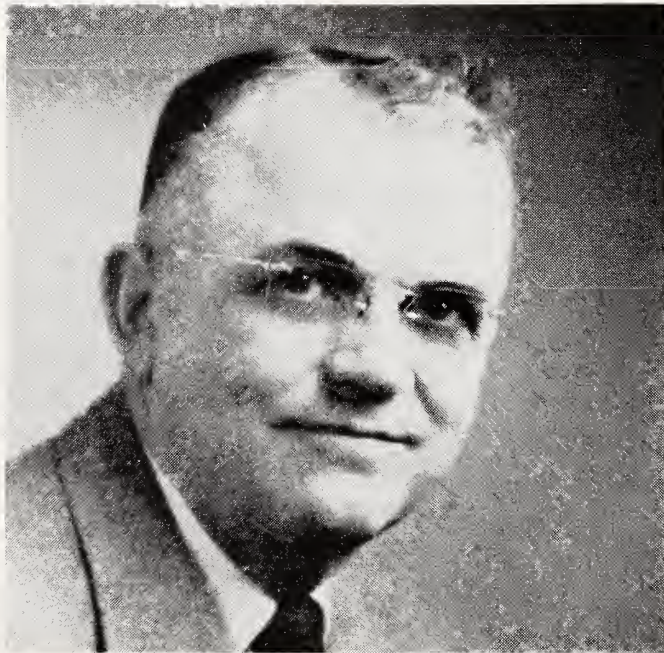
## **1964-1965**



**J. G. McDANIEL**  
President



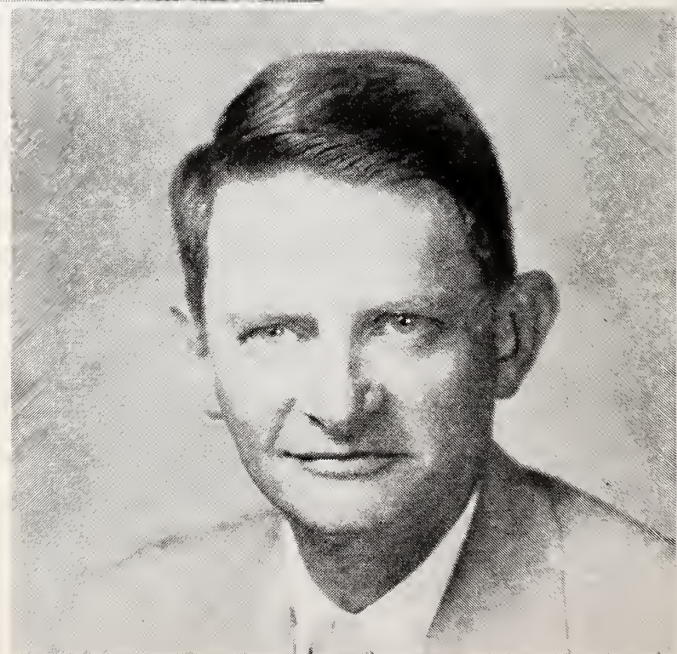
**J. K. TRAIN**  
First Vice President



**GEORGE H. ALEXANDER**  
President-Elect



**HENRY S. JENNINGS, JR.**  
Second Vice President



**JOHN T. MAULDIN**  
Secretary



# Medical Association of Georgia Officers, Committees, and Boards

Through May 4, 1965

## OFFICERS

*President*—J. G. McDaniel, Atlanta (1965)\*  
*President-Elect*—George H. Alexander, Forsyth (1965)\*  
*Immediate Past President*—George R. Dillinger, Thomasville (1965)\*  
*First Vice President*—John Kirk Train, Savannah (1965)\*  
*Second Vice President*—Henry S. Jennings, Jr., Gainesville (1965)  
*Chairman of Council*—A. W. Simpson, Washington (1965)\*  
*Secretary*—John T. Mauldin, Atlanta (1966)\*  
*Treasurer*—John S. Atwater, Atlanta (1965)\*  
*Speaker of the House*—J. Frank Walker, Atlanta (1965)

## HONORARY ADVISORY BOARD

<i>Past Presidents</i>	<i>Term</i>
J. W. Palmer, Ailey . . . . .	1918-1919
C. H. Richardson, Macon . . . .	1933-1934
Clarence L. Ayers, Toccoa . . . .	1934-1935
Grady N. Coker, Canton . . . . .	1938-1939
Allen H. Bunce, Atlanta . . . . .	1941-1942
James A. Redfearn, Albany . . . .	1942-1943
W. A. Selman, Atlanta . . . . .	1943-1944
A. M. Phillips, Macon . . . . .	1950-1951
William P. Harbin, Jr., Rome . . . .	1953-1954
H. D. Allen, Jr., Milledgeville . . .	1955-1956
W. Bruce Schaefer, Toccoa . . . .	1957-1958
Luther H. Wolff, Columbus . . . . .	1959-1960
Milford B. Hatcher, Macon . . . . .	1960-1961
Fred H. Simonton, Chickamauga . .	1961-1962
Thomas W. Goodwin, Augusta . . . .	1962-1963
George R. Dillinger, Thomasville . .	1963-1964

## COUNCILORS

### District

1—Charles E. Bohler, Brooklet (1967)  
2—W. Frank McKemie, Albany (1967)  
3—Frank A. Wilson, Leslie (1967)  
4—Virgil B. Williams, Griffin (1967)  
5—Floyd Sanders, Decatur (1965)  
6—William Rawlings, Sandersville (1965)  
7—Ralph N. Johnson, Rome (1965)  
8—F. G. Eldridge, Valdosta (1965)  
\*9—C. R. Andrews, Canton (1966)  
10—A. W. Simpson, Washington (1966)  
Georgia Medical Society  
Walter Brown, Savannah (1967)  
Richmond County Medical Society  
H. D. Pinson, Augusta (1966)  
Muscogee County Medical Society  
Luther H. Wolff, Columbus (1965)  
Bibb County Medical Society  
W. H. M. Weaver, Macon (1966)  
Fulton County Medical Society  
Charles S. Jones, Atlanta (1966)

## VICE COUNCILORS

### District

1—William Simmons, Sylvania (1967)  
2—J. C. Brim, Pelham (1967)  
3—J. T. Christmas, Vienna (1967)  
4—C. T. Cowart, LaGrange (1967)  
5—L. P. Matthews, Atlanta (1965)  
6—John Bell, Dublin (1965)  
7—W. C. Mitchell, Smyrna (1965)  
8—J. W. Yeomans, Jesup (1965)  
9—P. T. Scoggins, Commerce (1966)  
10—M. A. Hubert, Athens (1966)  
Georgia Medical Society  
T. A. Peterson, Savannah (1967)  
Richmond County Medical Society  
J. L. Mulherin, Augusta (1966)  
Muscogee County Medical Society  
Roy L. Gibson, Columbus (1965)  
Bibb County Medical Society  
Braswell E. Collins, Macon (1966)  
Fulton County Medical Society  
Linston H. Bishop, Atlanta (1966)

## DELEGATES TO AMA

<i>Delegate</i>	<i>Term Ending</i>
J. W. Chambers, LaGrange	(12-31-65)
J. Frank Walker, Atlanta	(12-31-66)

\*Executive Committee Members

## Alternate

Henry H. Tift, Macon (12-31-66)  
George R. Dillinger, Thomasville (12-31-65)  
Thomas W. Goodwin, Augusta (12-31-66)  
P. D. Ellington, Augusta (12-31-66)

## ASSOCIATION COMMITTEES

### EXECUTIVE COMMITTEE

J. G. McDaniel, Atlanta, President (1965)  
George H. Alexander, Forsyth, President-Elect (1965)  
George R. Dillinger, Thomasville, Immediate Past President (1965)  
John Kirk Train, Savannah, First Vice President (1965)  
Addison W. Simpson, Jr., Washington, Chairman of Council (1965)  
John T. Mauldin, Atlanta, Secretary (1966)  
Charles B. Andrews, Canton, Chairman of Finance (1965)  
John S. Atwater, Atlanta, Treasurer, Ex-officio (1965)

### FINANCE COMMITTEE

Charles R. Andrews, Canton, Chairman  
Charles E. Bohler, Brooklet  
W. Frank McKemie, Albany  
John S. Atwater, Atlanta, Ex-officio

### PROFESSIONAL CONDUCT COMMITTEE

Luther H. Wolff, Columbus, Chairman  
Milford B. Hatcher, Macon  
Fred H. Simonton, Chickamauga  
Thomas W. Goodwin, Augusta  
George R. Dillinger, Thomasville

### WOMAN'S AUXILIARY ADVISORY COMMITTEE

Ralph W. Fowler, Marietta, Chairman  
Remer Y. Clark, Marietta  
John E. Porter, Savannah  
John T. Leslie, Atlanta  
T. A. Peterson, Savannah  
Virgil B. Williams, Griffin, Ex-officio  
J. G. McDaniel, Atlanta, Ex-officio  
George H. Alexander, Forsyth, Ex-officio

## ASSOCIATION BOARDS

### BOARD OF ANNUAL SESSION

T. Q. Spitzer, Atlanta, Chairman (1968)  
Braswell Collins, Macon, Vice Chairman (1968)  
Thomas W. Goodwin, Augusta (1965)  
Luther H. Wolff, Columbus (1966)  
Robert E. Huie, Decatur (1967)

### ABNER W. CALHOUN LECTURESHIP COMMITTEE

A. Calhoun Witham, Augusta, Chairman (1971)  
J. E. Scarborough, Atlanta (1969)  
T. Q. Spitzer, Atlanta (1968)

### BOARD OF CONSTITUTION AND BY-LAWS

W. G. Elliott, Cuthbert, Chairman (1967)  
Virgil Williams, Griffin, Vice Chairman (1966)  
Alex Jones, Griffin (1965)  
George H. Alexander, Forsyth (1966)  
Peter L. Scardino, Savannah (1967)

### BOARD OF GOVERNMENTAL MEDICAL SERVICES

Luther H. Wolff, Columbus, Chairman (1967)  
W. Bruce Schaefer, Toccoa, Vice Chairman (1967)  
J. C. Thoroughman, Atlanta, (1966)  
Eugene L. Griffin, Atlanta (1965)  
Virgil B. Williams, Griffin (1965)

T. W. Goodwin, Augusta (1965)  
R. W. Edenfield, Macon (1966)  
Ruth M. Waring, Savannah (1967)  
Jack Hughston, Columbus (1966)  
A. E. Hauck, Atlanta (1966)

### Subcommittee on Crippled Children

Ruth M. Waring, Savannah, Chairman  
J. C. Hughston, Columbus, Vice Chairman  
F. J. Funk, Jr., Atlanta  
John L. Candler, Jr., Augusta  
H. M. Coe, Brunswick  
Robert Mabon, Atlanta  
James W. Bennett, Augusta  
W. G. Elliott, Cuthbert  
Atwood M. Freeman, Jr., Albany  
T. A. Amburgey, Savannah  
L. E. Dickey, Macon

### Subcommittee on Medical Indigency

A. E. Hauck, Atlanta, Chairman  
M. C. Adair, Washington, Vice Chairman  
Marvin Silverstein, Atlanta  
Charles R. Smith, Columbus  
James R. Winburn, Jr., Savannah  
S. K. Brown, Augusta  
Henry Jennings, Gainesville  
James N. Brawner, Atlanta  
E. B. Dunlap, Atlanta  
Charles P. Adams, Atlanta

### Subcommittee on Disaster Medical Care

Virgil B. Williams, Griffin, Chairman  
Charles E. Dowman, Atlanta, Vice Chairman  
Charles H. Richardson, Jr., Macon  
Harold M. Smith, Savannah  
Charles R. Smith, Columbus  
James W. Harkess, Augusta  
T. J. Ferrell, Waycross  
Donald W. Singleton, Atlanta  
J. L. Elliott, Savannah  
Clarence J. Sapp, Rome  
Lester Petrie, Atlanta, Ex-officio  
Mrs. Kells Boland, Atlanta, Ex-officio  
Paul T. Erickson, Atlanta, Ex-officio  
O. F. Whitman, Atlanta, Ex-officio  
Charles T. Brown, Guyton, Ex-officio

### Subcommittee on Maternal and Infant Welfare

Eugene L. Griffin, Atlanta, Chairman  
Morris Brackett, Atlanta, Secretary  
H. J. Bickerstaff, Columbus  
Peter Hydrick, East Point  
J. W. Smith, Manchester  
A. G. LeRoy, Thomson  
C. I. Bryans, Augusta  
Luella M. Klein, Atlanta  
John D. Thompson, Decatur  
F. P. Zupan, Augusta, Ex-officio

### Subcommittee on Public Health

R. W. Edenfield, Macon, Chairman  
Alex G. Little, Valdosta  
Lee H. Battle, Jr., Rome  
J. Miller Byne, Waynesboro  
Virgil B. Williams, Griffin  
Samuel U. Braly, Dallas

### Subcommittee on Rehabilitation

T. P. Goodwyn, Atlanta, Chairman  
C. J. Roper, Jasper  
Fred E. Murphy, Jr., Thomasville  
Samuel E. Patton, Macon  
W. O. White, Augusta  
Edgar O. Rand, Atlanta

### Subcommittee on School Child Health

Jack C. Hughston, Columbus, Chairman  
Fred L. Allman, Atlanta  
William H. Bonner, Athens  
Virginia McNamara, Atlanta  
M. D. Pittard, Toccoa



**Subcommittee on Veterans Affairs**

W. Bruce Schaefer, Toccoa, Chairman  
Lee Howard, Jr., Savannah  
F. P. Holder, Eastman

**BOARD OF HOSPITAL ACTIVITIES**

Milford B. Hatcher, Macon, Chairman (1965)  
Walter E. Brown, Savannah, Vice Chairman (1967)  
Rafe Banks, Jr., Gainesville (1966)  
Jack C. Norris, Atlanta (1965)  
Ralph N. Johnson, Rome (1967)

**Subcommittee on Blood Banks**

Jack C. Norris, Atlanta, Chairman  
H. V. Bell, Atlanta  
Walter Sheppard, Augusta  
Menard Ihnen, Augusta  
S. C. Rutland, Atlanta  
J. W. Iseman, Atlanta, Ex-officio

**Subcommittee on Hospital Relations**

Milford B. Hatcher, Macon, Chairman  
M. C. Adair, Washington  
Rafe Banks, Jr., Gainesville  
C. W. Mills, Jr., Atlanta  
P. W. Wurga, Athens

**BOARD OF INSURANCE AND ECONOMICS**

David R. Thomas, Jr., Augusta, Chairman (1967)  
William Moore, Atlanta, Vice Chairman (1965)  
H. D. Pinson, Augusta (1966)  
John T. Mauldin, Atlanta (1966)  
John H. Robinson, Americus (1967)  
Henry S. Jennings, Jr., Gainesville, (1965)

**Subcommittee on Relative Value Study**

Harry D. Pinson, Augusta, Chairman  
C. M. Silverstein, Atlanta  
Remer Y. Clark, Marietta  
Joseph E. Griffith, Marietta  
David R. Thomas, Jr., Augusta  
Henry S. Jennings, Jr., Gainesville

**Subcommittee on Medical Defense**

Charles S. Jones, Atlanta, Chairman  
John T. Mauldin, Atlanta  
Henry M. Finch, Atlanta  
J. Frank Walker, Atlanta

**BOARD OF INTERPROFESSIONAL RELATIONS**

William Coles, Atlanta, Chairman (1965)  
Henry Finch, Atlanta, Vice Chairman (1967)  
C. Daniel Cabaniss, Atlanta (1967)  
M. C. Adair, Washington (1966)  
Stephen T. Barnett, Jr., Atlanta (1966)  
Edgar D. Grady, Atlanta (1965)

**LIAISON COMMITTEE WITH GEORGIA STATE NURSES ASSOCIATION**

Charles Eberhart, Atlanta, Chairman  
Charles R. Underwood, Marietta  
J. Lamont Henry, Atlanta  
Jack M. Levin, Atlanta  
Thomas N. Lunsden, Clarkesville  
Samuel N. Patton, Macon

**BOARD OF LEGISLATION**

John A. Bell, Jr., Dublin, Chairman (1967)  
Harrison L. Rogers, Jr., Atlanta, Vice Chairman (1967)  
J. Frank Walker, Atlanta (1967)  
John M. Martin, Augusta (1966)  
Fred L. Allman, Atlanta (1965)  
Maurice Arnold, Hawkinsville (1965)  
Thomas Gilmore, Sandersville (1966)  
William Harbin, Rome (1965)

**Subcommittee on National Legislation**

J. Frank Walker, Atlanta, Chairman  
1st. District—W. W. Osborne, Savannah  
2nd. District—W. Frank McKemie, Albany  
3rd. District—Edmund M. Molnar, Columbus  
4th. District—Floyd R. Sanders, Decatur

5th. District—Harrison L. Rogers, Jr., Atlanta  
6th. District—Ernest E. Proctor, Jr., Newnan  
7th. District—Fred H. Simonton, Chickamauga  
9th. District—C. J. Roper, Jasper  
10th. District—R. H. Randolph, Athens

**Subcommittee on State Legislation**

John Bell, Dublin, Chairman  
Thomas Florence, Atlanta  
Frank P. Holder, Eastman  
Albert Deal, Statesboro  
Robert Quattlebaum, Valdosta  
W. R. Birdsong, Macon  
P. K. Dixon, Gainesville  
A. W. Simpson, Jr., Washington  
Jack Austin, Griffin  
Turner W. Rentz, Colquitt  
Lamar Mays, Atlanta  
T. A. Peterson, Savannah  
Samuel U. Braly, Dallas

**BOARD OF MEDICAL EDUCATION**

Thomas W. Goodwin, Augusta, Chairman (1966)  
T. A. Sappington, Thomaston, Vice Chairman (1967)  
J. W. Chambers, LaGrange (1967)  
Walter Bloom, Marietta (1965)  
Braswell Collins, Macon (1965)  
Ben K. Looper, Canton (1965)  
F. R. Jennings, Brunswick (1966)  
Harry B. O'Rear, Augusta, Ex-officio  
Arthur P. Richardson, Atlanta, Ex-officio

**Subcommittee on AMA-ERF**

Braswell Collins, Macon, Chairman  
J. W. Williams, Augusta  
C. B. Elliott, Cedartown  
Edgar Boling, Atlanta  
Mrs. Luther Vinton, Jr., Avondale Estates (Auxiliary)

**Subcommittee on Clarkesville Lab.**

Ben K. Looper, Canton, Chairman  
Sam Talmadge, Athens  
Hamil Murray, Gainesville  
Lee Howard, Jr., Savannah

**Subcommittee on Medical School Course**

T. A. Sappington, Thomaston, Chairman  
Linton H. Bishop, Atlanta  
Harry Harper, Augusta  
Wood Lovell, Atlanta  
William E. Barfield, Augusta

**BOARD OF OCCUPATIONAL HEALTH**

T. A. Peterson, Savannah, Chairman (1967)  
C. L. Ridley, Jr., Macon, Vice Chairman (1967)  
C. R. Andrews, Canton (1966)  
Thomas N. Lumsden, Clarkesville (1966)  
Joseph E. Griffith, Marietta (1966)  
L. H. Griffin, Claxton (1965)

**Subcommittee on Rural Health**

Thomas N. Lumsden, Clarkesville, Chairman  
Carl S. Pittman, Jr., Tifton  
J. S. Garner, Rome  
R. D. Walter, Calhoun

**BOARD OF PUBLIC SERVICE**

Linton H. Bishop, Atlanta, Chairman (1967)  
Robert E. Wells, Atlanta (1967)  
M. A. Hubert, Athens (1965)  
J. Rhodes Haverty, Atlanta (1966)  
Walter Bramblett, Forsyth (1965)  
E. J. Waits, Atlanta (1966)  
Harrison Reeves, Atlanta (1966)  
W. D. Stribling, Gainesville (1965)

**Subcommittee on Medicine and Religion**

Harrison Reeves, Atlanta, Chairman  
Frank P. Anderson, Jr., Augusta  
John Duncan Farris, Waycross

C. D. Cabaniss, Atlanta  
Curtis G. Hames, Claxton  
Joe S. Cruise, Atlanta  
James B. Dunaway, Griffin  
A. B. Dudley, Jr. Columbus  
Sidney Isenberg, Atlanta  
Samuel O. Poole, Gainesville  
Noah D. Meadows, Jr., Marietta  
Jasper T. Hogan, Jr., Macon  
M. Donald Pittard, Toccoa  
Thomas Q. Spitzer, Atlanta  
F. James Funk, Jr., Atlanta  
A. Bird Daniel, Statesboro  
Harry H. McGee, Jr., Savannah  
Maurice F. Arnold, Hawkinsville  
C. Markham Berry, Ellijay  
Thomas F. Sellers, Jr., Atlanta  
Robert A. Collins, Jr., Americus  
Dave Berman, Columbus  
W. A. Hopkins, Atlanta  
Earl T. McGhee, Dalton  
George M. Tolhurst, Cleveland  
W. J. Gower, Thomaston  
Robert L. Stump, Jr., Valdosta  
Ramon C. Thompson, Athens  
W. M. Newton, Moultrie  
B. T. Galloway, Brunswick  
Mark W. Fowler, Albany  
Frank L. Gibson, Bainbridge

**BOARD OF SPECIAL ACTIVITIES**

John S. Atwater, Atlanta, Chairman (1967)  
Frank A. Wilson, Jr., Leslie, Vice Chairman (1967)  
C. T. Cowart, LaGrange (1965)  
Leo Smith, Waycross (1966)  
Hoke Wammock, LaGrange (1966)  
C. L. Edwards, Dalton (1965)

**BOARD OF VOLUNTEER HEALTH AGENCY**

P. T. Scoggins, Commerce, Chairman (1967)  
F. G. Eldridge, Valdosta, Vice Chairman (1967)  
James N. Brawner, Atlanta (1966)  
Thomas L. Ross, Macon (1965)  
R. C. Pendergrass, Americus (1967)  
Donald R. Rooney, Marietta (1965)  
W. D. Stribling, Gainesville (1967)

**Subcommittee on Cancer**

R. C. Pendergrass, Americus, Chairman  
Ralph J. Davis, Rome  
John T. Mauldin, Atlanta  
Grady N. Coker, Canton  
Thomas Harrold, Macon  
Hoke Wammock, LeGrange  
Robert L. Brown, Atlanta  
John T. Godwin, Atlanta  
H. H. McGee, Jr., Savannah  
Menard Ihnen, Augusta

**Subcommittee on Mental Health**

1st. District—Abraham Center, Savannah  
2nd. District—E. E. Davis, Thomasville  
3rd. District—Frank A. Wilson, Leslie  
4th. District—L. C. Buchanan, Decatur  
5th. District—James N. Brawner, Atlanta  
6th. District—Thomas M. Hall, Macon  
7th. District—M. V. B. Teem, Marietta  
8th. District—Leo Smith, Waycross  
9th. District—W. D. Stribling, Gainesville, Chairman  
10th. District—J. Kenneth McDonald, Augusta  
Addison M. Duval, Atlanta, Ex-officio

**GEORGIA JOINT COUNCIL TO IMPROVE THE HEALTH CARE OF THE AGING**

J. John S. Atwater, Atlanta, Chairman  
Mrs. Nadine Bender, Tucker, Secretary  
Ernest Mingledorf, Atlanta  
Mr. Fred Gunter, East Point  
Mr. Glenn Hogan, Atlanta  
John H. Pritchett, Bremen  
Charles T. Cowart, LaGrange  
Mrs. Ann Dean, Tucker  
Mr. Harold Ward, Atlanta  
Mr. Milton Krueger, Atlanta, Ex-officio



# District Society Officers

## FIRST DISTRICT

Louis Griffin, Claxton, *President*  
V. J. Circincione, Savannah, *Secretary*

## SECOND DISTRICT

R. E. Jones, Tifton, *President*  
C. E. Finney, 716 N. Monroe, Albany,  
*Secretary*

## THIRD DISTRICT

Simone Brocato, Physicians Building,  
Columbus, *President*  
Robert Collins, 142 S. Jackson Street,  
Americus, *Secretary*

## FOURTH DISTRICT

Ernest E. Proctor, Jr., 35 Jefferson Street,  
Newnan, *President*  
J. O. St. John, 41 Jefferson Street, Newnan,  
*Secretary*

## FIFTH DISTRICT

Robert I. Gibbs, 2193 N. Decatur Road,  
Decatur, *President*  
Paul Teplis, 1293 Peachtree Street, N.E.,  
Atlanta 9, *Secretary*

## SIXTH DISTRICT

Hugh K. Sealy, 765 Spring Street, Macon,  
*President*  
W. A. Bootle, Jr., 700 Spring Street, Macon,  
*Secretary*

## SEVENTH DISTRICT

Byron H. Steele, Fairmount, *President*  
Clarence J. Sapp, 200 E. 3rd Street, Rome,  
*Secretary*

## EIGHTH DISTRICT

Duncan Farris, P.O. Box 399, Waycross,  
*President*  
Neal F. Yeomans, Waycross, *Secretary*

## NINTH DISTRICT

John H. Reed, 1128 Vine Street, N.E.,  
Gainesville, *President*  
Hamil Murray, Hall County Hospital,  
Gainesville, *Secretary*

## TENTH DISTRICT

M. C. Adair, Washington, *President*  
William Rawlings, Sandersville, *Secretary*

# Specialty Society Officers

## GEORGIA HEART ASSOCIATION

John L. Elliott, 212 E. Huntingdon  
Savannah, *President*  
Henry S. Jennings, Jr., 114 Vine Street,  
Gainesville, *Secretary*  
Mr. Linwood Beck, 58 Baltimore Place, N.W.,  
Atlanta 8, *Executive Secretary*

## GEORGIA PEDIATRIC SOCIETY

R. W. Blumberg, 69 Butler Street, S.E.,  
Atlanta 3, *President*  
L. C. Antrobus, 3130 Maple Drive, N.E.,  
Atlanta 5, *Secretary*

## GEORGIA SOCIETY OF OPHTHALMOLOGY & OTOLARYNGOLOGY

James T. King, 340 Boulevard, N.E., Atlanta,  
12, *President*  
A. Paul Keller, 1010 Prince Avenue, Athens,  
*Secretary*

## GEORGIA ASSOCIATION OF PATHOLOGISTS

Menard Ihnen, University Hospital, Augusta,  
*President*  
John T. Godwin, 265 Ivy Street, N.E.,  
Atlanta 3, *Secretary*

## GEORGIA SOCIETY OF ANESTHESIOLOGISTS

Z. W. Gramling, Talmadge Memorial Hospital,  
Augusta, *President*  
Frederick A. Carpenter, 89 Butler Street, S.E.,  
Atlanta 3, *Secretary*

## GEORGIA STATE OB. & GYN. SOCIETY

Jule C. Neal, 740 Hemlock Street, Macon,  
*President*  
B. A. McCrum, 420 E. Broad Street,  
Gainesville, *Secretary*

## GEORGIA ORTHOPEDIC SOCIETY

Floyd E. Bliven, Jr., Talmadge Memorial  
Hospital, Augusta, *President*  
Richard E. King, 340 Boulevard, N.E.,  
Atlanta 12, *Secretary*

## GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS

Duncan Shepard, 1211 W. Peachtree Street,  
N.E., Atlanta 9, *President*  
S. A. Roddenbery, 711 Center Street,  
Columbus, *Secretary*

## GEORGIA RADIOLOGICAL SOCIETY

C. M. Silverstein, 3451 Peachtree Road, N.E.,  
Atlanta 5, *President*  
David Robinson, 9 Medical Arts Center,  
Savannah, *Secretary*

## GEORGIA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Robert H. Vaughan, Physicians Building,  
Columbus, *President*  
Walter S. Dunbar, 384 Peachtree Street, N.E.,  
Atlanta 8, *Secretary*

## GEORGIA UROLOGICAL ASSOCIATION

David C. Williams, Jr., 1142 Druid Park  
Avenue, Augusta, *President*

## GEORGIA DIABETES ASSOCIATION

Harry Brill, Doctors Building, Columbus,  
*President*  
Lester Petrie, 47 Trinity Avenue, Atlanta 3,  
*Secretary*

## GEORGIA THORACIC SOCIETY

J. C. Robinson, 700 Spring Street, Macon,  
*President*

Coleman T. King, Battey State Hospital,  
Rome, *Secretary*  
Mr. Carl Fox, 5 Forsyth Street, N.W., 3rd  
Floor, Atlanta, *Executive Secretary*

## GEORGIA PSYCHIATRIC ASSOCIATION

Thomas M. Hall, 752 Hemlock Street, Macon,  
*President*  
Z. S. Sikes, 492 New Street, Macon, *Secretary*

## GEORGIA SOCIETY OF DERMATOLOGISTS

C. Conrad Smith, 1349 Druid Park Avenue,  
Augusta, *President*  
R. M. Reifler, 729 Pine Street, Macon,  
*Secretary*

## GEORGA ACADEMY OF GENERAL PRACTICE

J. Hubert Milford, Hartwell, *President*  
Lyle F. Herrman, P.O. Box 389, Hapeville,  
*Secretary*

## GEORGIA SOCIETY OF INTERNAL MEDICINE

Waddell Barnes, 781 Spring Street, Macon,  
*President*  
Max M. Blumberg, 33 Ponce de Leon Avenue,  
N.E., Atlanta 9, *Secretary*

## AMERICAN COLLEGE OF PHYSICIANS

Sterling Claiborne, 384 Peachtree St., N.E.,  
Atlanta 8, *President*

## GEORGIA CHAPTER, AMER. ASSN. OF PUBLIC HEALTH PHYSICIANS

J. F. Hackney, 99 Butler St., S.E., Atlanta 3,  
*President*  
Howard K. Sessions, Dept. of Public Health,  
Capitol Square, Atlanta 3, *Secretary*

# County Society Officers

## 1-ALTA MAHA-1964

J. A. Bedingfield, Baxley, President  
Horace L. Morgan, Baxley, Secretary

## 2-BALDWIN-1965

James B. Craig, Milledgeville, President  
A. C. Martinez, Milledgeville, Secretary

## 4-BARTOW-1965

Robert W. May, Jr., Cartersville, President  
Virginia Hamilton, Cartersville, Secretary

## 5-BEN HILL-IRWIN-1965

Morgan Smith, Fitzgerald, President  
Ralph Roberts, Fitzgerald, Secretary

## 6-BIBB-1965

W. Earl Lewis, Macon, President  
John T. DuPree, Macon, Secretary

## 7-BLUE RIDGE-1965

C. Markham Berry, Ellijay, President  
James M. Haymore, Blue Ridge, Secretary

## 8-BULLOCH-CANDLER-EVANS-1964

E. E. Bohler, Brooklet, President  
Albert M. Deal, Statesboro, Secretary

## 9-BURKE-1965

J. M. Byne, Jr., Waynesboro, President  
Charles G. Green, Waynesboro, Secretary

## CAMDEN-CHARLTON (See 24)

## 10-CARROLL-DOUGLAS-HARALSON-1965

Phil C. Astin, Jr., Carrollton, President  
Frank Green, Villa Rica, Secretary

## 11-GEORGIA MEDICAL SOCIETY-1965

Robert B. Gottschalk, Savannah, President  
J. J. Holloman, Savannah, Secretary

## 12-CHATTOOGA-1965

Herman E. Spivey, Summerville, President

## 13-CHATTAHOOCHEE-1965

Cecil L. Miller, Buford, President  
James H. Hunt, Duluth, Secretary

## 14-CHEROKEE-PICKENS-1964

John A. Cauble, Canton, President  
Evan Boddy, Woodstock, Secretary

## 15-CRAWFORD W. LONG-1965

Wm. V. Crosby, Athens, President  
Harvey Cabaniss, Athens, Secretary

## 16-CLAYTON-FAYETTE-1965

T. J. Busey, Fayetteville, President  
Wells Riley, Jonesboro, Secretary

## 17-COBB-1964

C. T. Henderson, Marietta, President  
E. A. Vaughan, Marietta, Secretary

## 18-COFFEE-1965

Calvin S. Meeks, Douglas, President  
John W. Herndon, Douglas, Secretary

## 19-COLQUITT-1965

James T. Flynn, Moultrie, President  
W. E. Harrison, Moultrie, Secretary

## COOK-BERRIEN (See 35)

## 20-COWETA-1965

J. W. Parks, Newnan, President  
W. E. Barron, Newnan, Secretary

## 21-DECATUR-SEMINOLE-1965

H. B. Baxley, Donalsonville, President  
M. A. Ehrlich, Bainbridge, Secretary

## 22-DEKALB-1965

J. E. Anthony, Jr., Decatur, President  
Catherine E. Foster, Decatur, Secretary

## 23-DOUGHERTY-1965

J. Daniel Bateman, Albany, President  
A. M. Freeman, Jr., Albany, Secretary

## 24-CAMDEN-CHARLTON-1964

G. W. Barker, St. Marys, President  
H. H. Robinson, Kingsland, Secretary

## 25-EMANUEL-1965

H. R. Frost, Swainsboro, President  
R. G. Brown, Swainsboro, Secretary

## 26-FLINT-1964

O. T. Gower, Cordele, President  
J. T. Cooper, Byromville, Secretary

## 27-FLOYD-1965

Cliff Moore, Rome, President  
Richard W. Leigh, Rome, Secretary

## 28-ELBERT-FRANKLIN-HART-1965

C. A. Mickel, Elberton, President  
John N. Shearouse, Lavonia, Secretary

## 29-FULTON-1965

Lamar B. Peacock, Atlanta, President  
William W. Moore, Jr., Atlanta, Secretary

## 30-GLYNN-1965

W. W. Payne, Brunswick, President  
Pearl B. Waddell, St. Simons Island, Secretary

## 31-GORDON-1964

R. D. Walter, Calhoun, President  
Byron Steele, Fairmount, Secretary

## 32-GRADY-1964

Martin Bailey, Cairo, President  
John Ferrence, Whigham, Secretary

## 33-HABERSHAM-1965

Thomas N. Lumsden, President  
T. O. Garrison, Cornelia, Secretary

## 34-HALL-1965

Harvey Newman, Gainesville, President  
Leland L. Pool, Gainesville, Secretary

## 35-COOK-BERRIEN-1965

Fred N. Clements, Adel, President  
Y. F. Carter, Jr., Nashville, Secretary

## 36-PEACH BELT-1965

A. S. Marshall, Ft. Valley, President  
Harry E. Sims, Ft. Valley, Secretary

## 37-JACKSON-BARROW-1965

Joe Griffith, Commerce, President  
A. A. Rogers, Jr., Commerce, Secretary

## 38-JASPER-1965

Ben C. Barrow, Monticello, President  
E. M. Lancaster, Shady Dale, Secretary

## 39-JEFFERSON-1964

George S. Pilcher, Louisville, President  
John J. Farris, Bartow, Secretary

## 40-JENKINS-1965

W. W. Hillis, Jr., Millen, President  
A. P. Mulkey, Millen, Secretary

## 41-LAMAR-1964

J. H. Jackson, Barnesville, President  
S. B. Traylor, Barnesville, Secretary

## 42-LAURENS-1965

Nelson S. Carswell, Dublin, President  
Ridley M. Glover, Dublin, Secretary

## 44-McDUFFIE-1965

E. L. Cook, Thomson, President  
John W. Lemley, Thomson, Secretary

## 45-MERI WETHER-HARRIS-1965

Wm. Chambliss, Hamilton, President  
Emmett Collins, Manchester, Secretary

## 46-MITCHELL-1965

M. W. Williams, Camilla, President  
A. A. McNeill, Jr., Camilla, Secretary

## 47-MUSCOGEE-1965

George R. Conner, Columbus, President  
E. M. Molnar, Columbus, Secretary

## 48-NEWTON-ROCKDALE-1965

T. L. Crews, Covington, President  
E. J. Callaway, Covington, Secretary

## 49-OCONEE VALLEY-1965

W. C. McGeary, Jr., Madison, President  
H. A. Thornton, Greensboro, Secretary

## 50-OCMULGEE-1965

Richard L. Smith, Cochran, President  
Ray L. Johnson, Eastman, Secretary

## PEACH BELT (See 36)

## 51-POLK-1965

Harold Goldin, Rockmart, President  
Ben Anderson, Cedartown, Secretary

## 52-RABUN-1964

J. C. Dover, Clayton, President  
John E. Fowler, Clayton, Secretary

## 53-RANDOLPH-STEWART-TERRELL-1965

Walter D. Martin, Dawson, President  
Carl E. Sills, Cuthbert, Secretary

## 54-RICHMOND-1965

Cecil A. White, Jr., Augusta, President  
Stuart H. Prather, Jr., Augusta, Secretary

## 55-SCREVEN-1965

Wm. R. Kent, Sylvania, President  
W. G. Simmons, Sylvania, Secretary

## 56-SOUTH GEORGIA-1965

T. H. Smith, Jr., Valdosta, President  
Byron S. Davis, Valdosta, Secretary

## 57-SOUTHEAST GEORGIA-1964

A. J. Yates, Soperton, President  
L. C. McRae, Glenwood, Secretary

## 58-SOUTHWEST GEORGIA-1964

Hinton Merritt, Colquitt, President  
R. E. Jennings, Arlington, Secretary

## 59-SPALDING-1965

Charles F. Leacher, Griffin, President  
Arthur Krepps, Griffin, Secretary

## 60-STEPHEN-1965

William D. Flory, Toccoa, President  
Charles M. Henry, Toccoa, Secretary

## 61-SUMTER-1964

Frank Castellow, Americus, President  
Harvey Simpson, Americus, Secretary

## 63-TAYLOR-1965

R. C. Montgomery, II, Butler, President  
E. C. Whatley, Reynolds, Secretary

## 64-TELFAR-1964

F. R. Mann, Jr., McRae, President  
D. B. McRae, McRae, Secretary

## 65-THOMAS-BROOKS-1965

John T. King, Jr., Thomasville, President  
Julian B. Neel, Thomasville, Secretary

## 66-TIFT-1964

Charles Zimmerman, Tifton, President  
F. Morris Davis, Tifton, Secretary

## 67-TRI COUNTY

## 68-TROUP-1965

Hoke Wammock, LaGrange, President  
Joseph F. Krafka, LaGrange, Secretary

## 69-UPSON-1965

Pruett Woodall, Thomaston, President  
L. L. Allen, Thomaston, Secretary

## 70-WALKER-CATOOSEA-DADE-1965

John C. Ellis, Rossville, President  
Gordon L. Hixson, Fort Oglethorpe, Secretary

## 71-WALTON-1965

Ralph E. Wenzel, Monroe, President  
C. C. Moreland, Monroe, Secretary

## 72-WARE-1965

S. W. Clark, Jr., Waycross, President  
J. Duncan Farris, Waycross, Secretary

## 73-WARREN-1964

H. B. Cason, Warrenton, President

## 74-WASHINGTON-1965

Louis R. Harvey, Sandersville, President  
Dean L. Holmes, Sandersville, Secretary

## 75-WAYNE-1965

Richard A. Moody, Jesup, President  
Daniel H. G. Glover, Jesup, Secretary

## 76-WHITFIELD-1965

Willard Carson, Chatsworth, President  
M. B. Lumpkin, Dalton, Secretary

## 78-WILKES-1965

J. E. Pollock, Jr., Washington, President  
C. E. Pollock, Jr., Washington, Secretary

## 79-WORTH-1964

J. L. Tracy, Sylvester, President  
H. G. Davis, Jr., Sylvester, Secretary



# Woman's Auxiliary Medical Association of Georgia 40th Annual Meeting

May 2-4, 1965

Augusta, Georgia



## PRESIDENT'S INVITATION

IT IS MY PLEASURE to welcome you to Augusta to the 40th Annual Meeting of the Woman's Auxiliary to the Medical Association of Georgia, May 2-4, 1965.

An informative, inspiring, and entertaining program has been planned with you in mind. We hope you will join us for all of our activities.

Mrs. John T. Leslie  
President  
Woman's Auxiliary To The MAG



## WELCOME TO AUGUSTA

IT IS AN HONOR for the Woman's Auxiliary to the Richmond County Medical Society to welcome you to the 40th Annual Meeting of the Woman's Auxiliary to the Medical Association of Georgia. It is our hope this convention will hold a special meaning for you and your Auxiliary.

If we can assist you in any way, it will be our pleasure.

Most Sincerely,  
Mrs. Julius T. Johnson  
President, Woman's Auxiliary to the  
Richmond County Medical Society

## The Program

### SUNDAY, MAY 2

8:30 **Registration**  
to Second Floor  
3:30 Augusta Town House  
HOSPITALITY, *Telfair Room*

12:30 **Pre-Convention Executive Board Meeting—Dutch Luncheon (Georgian Room)**

PRESIDING: MRS. JOHN T. LESLIE,  
Avondale Estates, *President*

INVOCATION: MRS. JAMES N. BRAWNER,  
Sr., Atlanta  
(Honorary President for Life)

PLEDGE OF LOYALTY AND  
COLLECT: MRS. EARL T. MCGHEE,  
Dalton

4:30 **MAG General Business Session (Embassy Room)**

(All MAG and Auxiliary Members and  
Guests Invited)

PRESIDING: J. G. MCDANIEL, M.D.,  
Atlanta, *President*

### MONDAY, MAY 3

8:30 **Registration**  
to Second Floor  
3:30 Augusta Town House  
HOSPITALITY, *Telfair Room*

**9:00 MAG General Business Session and House of Delegates Meeting (Embassy Room)**  
 (All MAG and Auxiliary Members and Guests Invited)  
**PRESIDING:** J. G. McDANIEL, M.D., Atlanta, *President*  
**REPORT OF PRESIDENT, WOMAN'S AUXILIARY TO MAG:** MRS. JOHN T. LESLIE, Avondale Estates

**9:00 Auxiliary General Meeting (Georgian Room)**  
**CALL TO ORDER—**MRS. JOHN T. LESLIE, Avondale Estates  
**INVOCATION—**REV. LAWRENCE BRADLEY, *Pastor*, Curtis Baptist Church, Augusta  
**PLEDGE OF ALLEGIANCE AND COLLECT:** MRS. JOHN SCHREEDER, Chamblee, *President*, DeKalb County Auxiliary  
**ADDRESS OF WELCOME:** MRS. JULIUS T. JOHNSON, Augusta, *President*, Richmond County Auxiliary  
**RESPONSE TO WELCOME:** MRS. JOHN M. MILLER, *President*, South Georgia Auxiliary  
**PRESENTATION OF CONVENTION PLANS—**MRS. F. N. HARRISON, Augusta  
**INTRODUCTION OF PAGES FOR THE DAY—**MRS. HERBERT HARPER, Augusta  
**REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY TO THE MAG—**RALPH W. FOWLER, SR., M.D., Marietta

#### Greetings

**PRESIDENT OF MAG—**J. G. McDANIEL, M.D., Atlanta  
**PRESIDENT-ELECT OF MAG—**GEORGE ALEXANDER, M.D., Forsyth  
**INTRODUCTIONS OF PAST PRESIDENTS, HONOR GUEST, AND GUEST SPEAKER—**MRS. WALKER CURTIS, College Park  
**ADDRESS:** MRS. EARL W. ROLES, Louisville, Kentucky, *Southern Regional Vice-President* Auxiliary to American Medical Association

#### Business Session

(All reports limited to two minutes)  
**CONVENTION RULES OF ORDER—**MRS. JAMES SKINNER, Griffin, *Parliamentarian*  
**ROLL CALL AND MINUTES—**MRS. E. E. DAVIS, Thomasville, *Secretary*  
**REPORTS—***President:* MRS. JOHN T. LESLIE, Avondale Estates

*President-Elect:* MRS. LOUIS H. GRIFFIN, SR., Claxton  
*Treasurer:* (Including Auditor's Report): MRS. JOHN A. MEIER, Albany

#### ADDENDUM REPORTS—

Complete Reports (As given in 1964-65 Annual Report Book)

#### RECOMMENDATIONS FROM THE EXECUTIVE BOARD—

**REPORT OF REVISIONS COMMITTEE:** MRS. W. A. WILKES, Augusta, *Chairman*

**REPORT OF CREDENTIALS COMMITTEE—**MRS. QUIMBY HAIR, Augusta, *Chairman*

#### ANNOUNCEMENTS

#### 11:30 RECESS OF SESSION

#### 12:30 Guest Day—Recognition Luncheon (Dutch) (Georgian Room)

Honoring County Presidents, Presidents-Elect and District Councilors (all attending Convention Invited)

**PRESIDING—**MRS. LOUIS H. GRIFFIN, SR., Claxton, *President-Elect*

**GUEST SPEAKER—**MRS. AARON E. MARGULIS, Chicago, *Field Representative* Women's Organizations, A.M.A.

#### 12:30 Past Presidents' Luncheon (Dutch) (Augusta Woman's Club—1005 Milledge Road)

(For Past Presidents of Woman's Auxiliary to MAG)

**PRESIDING—**MRS. JOHN E. PORTER, Savannah, *Immediate Past President*

#### 2:00 to 4:30 Guest Day Tour and Tea (Gracewood Hospital)

### TUESDAY, MAY 4

#### 7:30 President-Elect's "Early-Bird" Breakfast (Dutch) (Queen's Room)

(1965-66 Executive Board)

**PRESIDING—**MRS. LOUIS H. GRIFFIN, SR., Claxton, *President-Elect*

#### 8:30 to 11:30 Registration to Augusta Town House

**HOSPITALITY—**Telfair Room

#### 9:00 Continued General Meeting (Georgian Room)

**CALL TO ORDER—**MRS. JOHN T. LESLIE

**INVOCATION—**DR. CHARLES H. GIBBONEY, *Pastor*, Reid Memorial Presbyterian Church, Augusta



IN MEMORIAM—MRS. MARTIN RHODE,  
Augusta

INTRODUCTION OF PAGES FOR THE  
DAY—MRS. HERBERT HARPER, Augusta

PRESENTATION OF CONVENTION  
PLANS—MRS. W. O. WHITE, JR.,  
Augusta

### **Business Session**

(All reports limited to two minutes)

ROLL CALL AND MINUTES—  
MRS. E. E. DAVIS, *Secretary*

INTRODUCTION OF DISTRICT  
COUNCILORS—MRS. LOUIS H. GRIFFIN,  
SR.

### **COUNTY PRESIDENTS' REPORTS**

REPORT OF REVISIONS COMMIT-  
TEE—MRS. W. A. WILKES, Augusta

REPORT OF BUDGET AND FINANCE  
COMMITTEE—  
MRS. WILLIAM PENDERGRAST, Atlanta

REPORT OF RESOLUTIONS COMMIT-  
TEE—MRS. NEIL YEOMANS, Waycross

REPORT OF CREDENTIALS COMMIT-  
TEE—MRS. L. Q. HAIR, Augusta

REPORT OF COURTESY COMMIT-  
TEE—MRS. Z. SWEENEY SIKES, Macon

REPORT OF AWARDS COMMITTEES:  
Achievement—MRS. FLOYD SANDERS,  
JR., Decatur

Disaster Preparedness—MRS. GEORGE  
BROWN, Griffin

AMA-ERF—MRS. LUTHER VINTON,  
Avondale Estates

Mrs. J. Boner White Scrapbook—  
MRS. ROY DUNCAN, Marietta

Marie F. Burns Safety—MRS. ABRAM  
GOLDSMITH, Albany

Brawner Trophy of General Excellence—  
MRS. JOHN E. PORTER, Savannah

REPORT OF NOMINATING COMMIT-  
TEE—MRS. A. WORTH HOBBY, Atlanta

### **ELECTION OF OFFICERS**

INSTALLATION OF OFFICERS—  
MRS. RALPH CHANEY, Augusta,  
*Past President*

PRESENTATION OF PRESIDENT'S PIN  
AND GAVEL—MRS. JOHN T. LESLIE,  
(Retiring President) Avondale Estates

INAUGURAL ADDRESS AND  
ANNOUNCEMENTS OF 1965-66  
CHAIRMANSHIPS—

MRS. L. H. GRIFFIN, SR., Claxton

PRESENTATION OF PAST  
PRESIDENT'S PIN—

MRS. JOHN PORTER, Savannah

### **ANNOUNCEMENTS**

ADJOURNMENT PROMPTLY AT  
12:00 NOON

### **1:00 Luncheon and Davison's Fashion Show (Old Medical College, 6th and Telfair St.)**

PRESIDING: MRS. JOHN T. LESLIE,  
Avondale Estates

INVOCATION: MRS. JOHN MCCAIN,  
Decatur

### **2:30 MAG General Business Session and House of Delegates Second Meeting (Embassy Room, Augusta Town House) (All MAG and Auxiliary Members and Guests Invited)**

ADJOURNMENT OF ANNUAL  
SESSION

### **Rules to Govern the Convention**

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
4. Badges must be worn by members of the voting body during all general sessions of the convention.
5. Delegates' privileges are not transferable.
6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by the persons making and seconding the motion.
7. All original motions on resolutions shall be made by submitting two copies, one to the Resolution Committee and one to the Recording Secretary.
8. All persons appearing on the program must be seated near the platform when the session opens. Whispering greatly retards the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

# ORGANIZATION OF THE WOMAN'S AUXILIARY to the MEDICAL ASSOCIATION OF GEORGIA 1964-1965 Officers

MRS. JOHN T. LESLIE . . . . .	<i>President</i>
19 Wiltshire Drive, Avondale Estates, Georgia	
MRS. LOUIE H. GRIFFIN, SR. . . . .	<i>President-Elect</i>
306 Hendrix Street, Claxton, Georgia	
MRS. S. WILLIAM CLARK . . . . .	<i>First Vice President</i>
1710 Camellia Drive, Waycross, Georgia	
MRS. HAYWARD PHILLIPS . . . . .	<i>Second Vice President</i>
1082 Bertram Road, Augusta, Georgia	
MRS. MILTON BRYANT . . . . .	<i>Third Vice President</i>
3525 Old Ivy Lane, N.E., Atlanta 5, Georgia	
MRS. E. E. DAVIS . . . . .	<i>Recording Secretary</i>
1202 E. Washington Street, Thomasville, Georgia	
MRS. HOWARD LEE . . . . .	<i>Corresponding Secretary</i>
2141 Spring Creek Road, Decatur, Georgia	
MRS. JOHN A. MEIER . . . . .	<i>Treasurer</i>
510 Pinecrest Drive, Albany, Georgia	
MRS. JAMES H. MANNING . . . . .	<i>Historian</i>
657 Kennesaw, Marietta, Georgia	
MRS. JAMES M. SKINNER . . . . .	<i>Parliamentarian</i>
1123 Maple Drive, Griffin, Georgia	

## Advisory Committee

Dr. Ralph W. Fowler, <i>Chairman</i> . . . . .	Marietta
Dr. J. G. McDaniel, <i>President, Ex-Officio</i> . . . . .	Atlanta
Dr. George Alexander, <i>President-elect, Ex-Officio</i> . . . . .	Forsyth
Dr. Virgil B. Williams, <i>Ex-Officio</i> . . . . .	Griffin
Dr. Remer Y. Clark . . . . .	Marietta
Dr. John E. Porter . . . . .	Savannah
Dr. T. A. Peterson . . . . .	Savannah
Dr. John T. Leslie . . . . .	Atlanta

## Chairmen of Standing Committees

<i>Achievement Awards</i> . . . . .	MRS. FLOYD R. SANDERS, JR. 206 Upland Road, Decatur, Georgia
<i>American Medical Association</i>	
<i>Education and Research Foundation</i> . . . . .	MRS. LUTHER VINTON, JR. 1043 Lakeshore Drive, Avondale Estates
<i>Archives</i> . . . . .	MRS. JOHN R. MCCAIN 719 W. Ponce de Leon Avenue, Decatur, Georgia
<i>Auxiliary Headquarters</i> . . . . .	MRS. HUGH COLQUITT 805 Talcott Circle, Marietta, Georgia
<i>Browner Trophy</i> . . . . .	MRS. JOHN E. PORTER 501 E. 53rd Street, Savannah, Georgia
<i>Budget and Finance</i> . . . . .	MRS. WILLIAM J. PENDERGRAST 3398 Briarcliff Road, N.E., Atlanta, Georgia
<i>Bulletin</i> . . . . .	MRS. JOHN T. GODWIN 1164 Springdale Road, N.E., Atlanta, Georgia
<i>By-Laws and Procedures</i> . . . . .	MRS. WM. A. WILKES 1203 Highland Avenue, Augusta, Georgia
<i>Disaster Preparedness</i> . . . . .	MRS. GEORGE W. BROWN 672 E. College Street, Griffin, Georgia
<i>Community Service</i> . . . . .	MRS. HAYWARD PHILLIPS 1082 Bertram Road, Augusta, Georgia
<i>Doctor's Day</i> . . . . .	MRS. FRANK E. MORGAN, JR. 268 Woodview Drive, Decatur, Georgia
<i>Editorial</i> . . . . .	MRS. ROBERT MAINOR 544 Lee Street, Smyrna, Georgia
<i>Health Careers</i> . . . . .	MRS. W. A. MENDENHALL 3830 Chamblee-Dunwoody Road, Chamblee, Georgia
<i>International Health</i> . . . . .	MRS. HOWARD SIGAL 100 Montclair Drive, Smyrna, Georgia
<i>Legislation</i> . . . . .	MRS. MILTON F. BRYANT 3525 Old Ivy Lane, N.E., Atlanta 5, Georgia
<i>Membership</i> . . . . .	MRS. LOUIE H. GRIFFIN, SR. 306 Hendrix Street, Claxton, Georgia
<i>Mental Health</i> . . . . .	MRS. CHARLES SMITH 2620 Foley Drive, Columbus, Georgia
<i>Program</i> . . . . .	MRS. S. WILLIAM CLARK, JR. 1710 Camellia Drive, Waycross, Georgia
<i>Research in Romance of Medicine</i> . . . . .	MRS. RICHARD B. EWING 1834 Waverland Circle, Macon, Georgia
<i>Rural Health</i> . . . . .	MRS. EARL T. MCGHEE 808 Atkinson Drive, Dalton, Georgia
<i>Safety</i> . . . . .	MRS. ABRAHAM O. GOLDSMITH 1907 Lynwood Drive, Albany, Georgia
<i>Scrapbook</i> . . . . .	MRS. ROY G. DUNCAN 418 Seminole Drive, Marietta, Georgia
<i>State Handbook</i> . . . . .	MRS. ENNIS WALDERMAYER 1026 South Lee Street, Americus, Georgia
<i>W. R. Dancy M.D. Student Loan Fund</i> . . . . .	MRS. W. N. AGOSTAS 2302 Overton Road, Augusta, Georgia

## Chairman of Special Committee

<i>Crawford W. Long Note Paper</i> . . . . .	MRS. BERT MALONE 402 Third Avenue, Brunswick, Georgia
--	--

## District Councilors

<i>First</i> —MRS. JOHN D. MCARTHUR . . . . .	Lyons
<i>Second</i> —MRS. CHARLES E. FINNEY . . . . .	1609 Gary Ave., Albany
<i>Third</i> —MRS. FREDERICK H. THOMPSON . . . . .	417 Judy Lane, Americus
<i>Fourth</i> —MRS. R. J. MINCEY . . . . .	Box 829, Thomaston
<i>Fifth</i> —MRS. F. W. DOWDA . . . . .	4824 Northside Dr., N.W., Atlanta
<i>Sixth</i> —MRS. GEORGE H. ALEXANDER . . . . .	Forsyth
<i>Seventh</i> —MRS. FRANK A. BLALOCK . . . . .	Batley Hospital, Rome
<i>Eighth</i> —MRS. CALVIN MEEKS, JR. . . . .	Ocilla Rd., Douglas
<i>Ninth</i> —MRS. JOHN H. REED . . . . .	1314 Springdale Road, N.E., Gainesville
<i>Tenth</i> —MRS. JOHN WILKINS . . . . .	390 West View Drive, Athens

## Councilor

### Woman's Auxiliary to the Southern Medical Association

MRS. CARL P. SAVAGE, SR.  
511 Dooley Street, Montezuma

## County Presidents and Presidents-Elect

<i>Baldwin</i> . . . . .	President Mrs. Wilbur E. Baugh 1739 Elmwood Road, Milledgeville
<i>Bibb</i> . . . . .	President Mrs. Z. Sweeney Sikes, Jr. 259 Idlewild Road, Macon
	President-Elect Mrs. William W. Orr, 2187 General Winship Drive, Macon
<i>Bulloch-Candler-Evans</i> . . . . .	President Mrs. John D. Deal 409 Donahoo Street, Statesboro
	President-Elect Mrs. C. Emory Bohler P. O. Box 8, Brooklet
<i>Carroll-Douglas-Haralson</i> . . . . .	President Mrs. Steve Worthy 227 West Avenue, Carrollton
	President-Elect Mrs. Harvey Beall 2395 Lakeshore Drive, Carrollton
<i>Chatham</i> . . . . .	President Mrs. Mel Berlin 17 Broadmoor Circle, Savannah
<i>Cherokee-Pickens</i> . . . . .	President Mrs. Grady Coker Canton
<i>Clarke</i> . . . . .	President Mrs. Gerard B. Creagh 555 Milledge Circle, Athens
<i>(Crawford W. Long)</i>	President-Elect Mrs. Wm. V. Crosby Dellwood Drive, Athens
<i>Cobb</i> . . . . .	President Mrs. Robert D. May Rt. 1 Roberts Road, Kennesaw
	President-Elect Mrs. A. M. Rose 172 Arnold Avenue, Marietta
<i>Coffee</i> . . . . .	President Mrs. Ed Bell Ocilla Road, Douglas
	President-Elect Mrs. Tom Stapleton Lee Avenue, Douglas
<i>Colquitt</i> . . . . .	President Mrs. Robert Joiner 918 3rd Street, S.W., Moultrie
	President-Elect Mrs. Preston D. Conger 835 4th Street, S.W., Moultrie
<i>Decatur-Seminole</i> . . . . .	President Mrs. L. W. Willis, Sr. 507 E. Broughton Street, Bainbridge
<i>DeKalb</i> . . . . .	President Mrs. John M. Schreeder 4165 Chamblee-Dunwoody Road Chamblee
	President-Elect Mrs. George Statham 2211 Hill Park Court, Decatur
<i>Dougherty</i> . . . . .	President Mrs. Charles M. Holman 1104 Pinecrest Drive, Albany
	President-Elect Mrs. W. Frank McKemie 1100 Pinecrest Drive, Albany
<i>Elbert-Franklin-Hart</i> . . . . .	President Mrs. John Shearouse Hartwell Street, Lavonia
<i>Flint</i> . . . . .	President Mrs. P. L. Williams Americus Road, Cordele
<i>(Crisp, Turner, Dooly)</i>	President-Elect Mrs. Joe Christmas, Vienna
<i>Floyd</i> . . . . .	President Mrs. Richard Gray 2 Crestwood Drive, Rome
	President-Elect Mrs. Larry Cauthen Rt. 1, Rome
<i>Fulton</i> . . . . .	President Mrs. John W. Thompson 3814 Vermont Road, N.E., Atlanta
<i>Glynn</i> . . . . .	President Mrs. E. R. Jennings 4029 Riverside Drive, Brunswick
	President-Elect Mrs. W. A. Snyder Country Club Pl., Brunswick
<i>Gordon</i> . . . . .	President Mrs. Wm. R. Thompson 105 Victory Drive, Calhoun
	President-Elect Mrs. J. Leroy Rabb Hillcrest Drive, Calhoun
<i>Grady</i> . . . . .	President Mrs. John Ferrence Whigham



*Habersham-Towns-White* . . . . . President Mrs. Bill Ariail  
Chase Road, Cornelia

*Hall-Lumpkin* . . . . . President Mrs. Hartwell Joiner  
726 Dixon Drive, N.W., Gainesville

*Mitchell* . . . . . President Mrs. William C. Arwood  
N. Legion Drive, Pelham

*Muscogee* . . . . . President Mrs. Luther J. Roberts  
2208 Springdale Drive, Columbus  
President-Elect Mrs. George Conner  
2517 Hilton, Columbus 31906

*Ocmulgee (Bleckley, Dodge, Pulaski, Wilcox)*  
President Mrs. Roy L. Johnson  
204 9th Avenue, Eastman

*Peach Belt* . . . . . President Mrs. Carl L. Beard  
117 Briarcliff Road, Warner Robins

*Richmond* . . . . . President Mrs. Julius Johnson  
819 Milledge Road, Augusta

*South Georgia* . . . . . President Mrs. John M. Miller  
2419 Briarwood Drive, Valdosta  
(Lowndes, Lanier, Berrien, Cook, Clinch)  
President-Elect Mrs. Charles Hodges  
2107 Azalea Drive, Valdosta

*Southeast Georgia* . . . . . President Mrs. A. J. Yates, Jr.  
Soperton

*Southwest Georgia* . . . . . President Mrs. H. W. Wall  
(Calhoun, Early, Miller, Baker, Clay) 524 Flowers Drive, Blakely

*Spalding* . . . . . President Mrs. H. A. Foster  
909 Mockingbird Lane, Griffin  
President-Elect Mrs. James M. Skinner  
1123 Maple Drive, Griffin

*Stephens* . . . . . President Mrs. Claude E. Bennett  
104 Willowdell Drive, Toccoa  
President-Elect Mrs. W. H. Good, Jr.  
Orlando Drive, Toccoa

*Sumter-Schley-Macon-Marion* . . . . . President Mrs. W. R. Anderson  
411 Judy Lane, Americus  
President-Elect Mrs. William McMath  
Daniel Street, Americus

*Thomas-Brooks* . . . . . President Mrs. E. Davis  
1202 E. Washington, Thomasville

*Tift* . . . . . President Mrs. F. Morris Davis  
402 Fulwood Blvd., Tifton  
President-Elect Mrs. R. E. Jones  
1015 Love Avenue, Tifton

*Troup-Heard* . . . . . President Mrs. E. Descombe Wells, Jr.  
301 N. Lewis Street, LaGrange  
President-Elect Mrs. J. Render Turner  
1420 Vernon Road, LaGrange

*Upson* . . . . . President Mrs. W. J. Gower  
806 Avalon Road, Thomaston  
President-Elect Mrs. W. M. Dallas, Jr.  
110 Garden Terrace, Thomaston

*Walker-Catoosa-Dade* . . . . . President Mrs. Leroy Sherrill  
1701 S. Clayton Avenue  
Chattanooga, Tenn.  
President-Elect Mrs. Wm. D. Crawley  
4409 Drummond, Chattanooga, Tenn.

*Ware* . . . . . President Mrs. Neal F. Yeomans  
704 Magnolia Street, Waycross

*Wayne* . . . . . President Mrs. E. L. Harrell  
5425 Mason Street, Jesup

*Whitfield-Murray* . . . . . President Mrs. Murray Benham Lumpkin  
407 W. Emory Street, Dalton  
President-Elect Mrs. John Looper  
Walnut Avenue, Dalton

*Worth* . . . . . President Mrs. J. L. Tracy, Jr.  
508 N. Main Street, Sylvester

## Past Presidents and Conventions

### Honorary Presidents for Life

Mrs. James N. Brawner, Sr., Atlanta  
Mrs. Eustace A. Allen, Atlanta

1924—Augusta (Organization)—Mrs. C. W. Roberts, Atlanta  
(Deceased), Temporary Chairman

1925—Atlanta—Mrs. James N. Brawner, Sr., Atlanta

1926—Albany—Mrs. William H. Myers, Savannah

1927—Athens—Mrs. C. W. Roberts, Atlanta (Deceased)

1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore,  
Gaffney, S. C.)

1929—Macon—Mrs. Charles C. Hinton, Macon

1930—Augusta—Mrs. Marion T. Benson, Atlanta (Deceased)

1931—Macon—Mrs. Charles C. Harrold, Macon (Deceased)

1932—Savannah—Mrs. Ralston Lattimore, Savannah

1933—Macon—Mrs. S. T. R. Revell, Louisville

1934—Augusta—Mrs. J. Bonar White, Atlanta (Deceased)

1935—Atlanta—Mrs. J. E. Penland, Waycross

1936—Savannah—Mrs. Ernest Harris, Winder (Deceased)

1937—Macon—Mrs. W. R. Dancy, Savannah

1938—Augusta—Mrs. Ralph H. Chaney, Augusta

1939—Atlanta—Mrs. Warren A. Coleman, Eastman

1940—Savannah—Mrs. Eustace A. Allen, Atlanta

1941—Macon—Mrs. H. G. Bannister, Ila

1942—Augusta—Mrs. Lee Howard, Savannah

1943—Atlanta—Mrs. J. Lon King, Macon

1944—Savannah—Mrs. Olin S. Cofer, Atlanta

1945—No Convention

1946—Macon—Mrs. W. T. Randolph, Winder

1947—Augusta—Mrs. W. Bruce Schaefer, Toccoa

1948—Atlanta—Mrs. W. G. Elliott, Cuthbert

1949—Savannah—Mrs. S. A. Anderson, Atlanta

1950—Macon—Mrs. J. Harry Rogers, Atlanta

1951—Augusta—Mrs. Lehman W. Williams, Savannah

1952—Atlanta—Mrs. J. R. S. Mays, Macon

1953—Savannah—Mrs. Ralph W. Fowler, Marietta (Deceased)

1954—Macon—Mrs. Leo Smith, Waycross

1955—Augusta—Mrs. Shelley C. Davis, Atlanta

1956—Atlanta—Mrs. Robert C. Major, Augusta

1957—Savannah—Mrs. Walker L. Curtis, College Park

1958—Macon—Mrs. John L. Elliott, Savannah

1959—Augusta—Mrs. Luther H. Wolff, Columbus

1960—Columbus—Mrs. Remer Y. Clark, Marietta

1961—Atlanta—Mrs. W. P. Rhyne, Albany

1962—Savannah—Mrs. A. Worth Hobby, Atlanta

1963—Jekyll Island—Mrs. Ennis W. Waldemayer, Americus

1964—Macon—Mrs. John E. Porter, Savannah

## CONVENTION COMMITTEES WOMAN'S AUXILIARY TO THE RICHMOND COUNTY MEDICAL SOCIETY

### General Chairmen

Mrs. F. N. Harrison, Chairman  
Mrs. Wm. O. White, Jr., Co-Chairman

**Credentials and Registration**  
Mrs. L. Q. Hair, Chairman

### Publicity

Mrs. William A. Fuller, Chairman

### Memorial Service

Mrs. C. Martin Rhode, Chairman

**Display and Meeting Room**  
Mrs. C. Iverson Bryans, Chairman

### Transportation

Mrs. John W. Kemble, Chairman

### Tea

Mrs. Norman Pursley, Chairman

### Information and Hostesses

Mrs. Jack Lindley, Chairman

### Hospitality

Mrs. William A. Wilkes, Chairman  
Mrs. Mason H. Shepherd, Co-Chairman

### Executive Board Meetings

Mrs. Clyde Burgamy, Chairman

### Past President's Luncheon

Mrs. Ralph Chaney, Chairman  
Mrs. Walter L. Shepeard, Co-Chairman

### Guest Day—Recognition Luncheon

Mrs. Theodore Everett, Chairman  
Mrs. Gordon Kelly, Co-Chairman

### Luncheon

Mrs. William Steed, Chairman

### Fashion Show

Mrs. Kenneth Carrington, Chairman  
Mrs. E. Val Hastings, Co-Chairman

### Flowers For Special Events

Mrs. Charles M. Rhode, Chairman

### Pages

Mrs. Herbert S. Harper, Chairman

### Printing and Favors

Mrs. James R. Bryan, Chairman  
Mrs. Harry D. Scoggins, Co-Chairman

### Social Hour and Banquet

Mrs. Stephen Brown, Chairman

### Tellers

Mrs. George Statham, Decatur  
Mrs. Luther Roberts, Columbus

### Timekeepers

Mrs. W. P. Stoner, Sylvester  
Mrs. Gerard B. Creagh, Athens

### Reading Committee

Mrs. John Wilkins, Athens  
Mrs. Floyd Sanders, Decatur  
Mrs. Earl McGhee, Dalton

### Pledge of Loyalty to the

**Woman's Auxiliary  
Medical Association of Georgia**

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation, and ever sustain its high ideals."

### Collect

"Keep us, O God, from pettiness; let us be large in thought, word and deed. Let us be done with faultfinding, and leave off self-seeking. May we put away pretense, and meet each other face to face, without self-pity and without prejudice.

May we never be hasty in judgment, and always generous. Let us take time for all things; make us to grow calm, serene, gentle. Teach us to put into action our better impulses, straightforward and unafraid. Grant that we may realize it is the little things that create differences; but in the big things of life we are one.

And, may we strive to reach and to know the great, common woman's heart of us all, and O, Lord, let us not forget to be kind."

# COMPLICATIONS OF ENDOSCOPY

John B. Blalock, M.D., *New Orleans, Louisiana*

- **A constant awareness of the possibility of injury to the tracheobronchial tree and esophagus will minimize these complications.**

THE LOW INCIDENCE of major complications of endoscopy would seem to render such sequelae of minor concern. They occur about once in every 400 to 500 esophagoscopies and apparently only once in several thousand bronchoscopies and gastroscopies.<sup>1-4</sup> These complications seem to be an occasionally inevitable accompaniment of these valuable diagnostic and therapeutic procedures, and we must be prepared to cope with them when they occur. They gain significance because of the large numbers of endoscopies being done and the gravity of the complications when they do occur.

Endoscopic complications may be classified into those due to the anesthetic, usually a topical one, and those due to instrumentation. There are good explanations for the fact that anesthetic complications are associated predominantly with bronchoscopy, and instrumental complications with esophagoscopy and gastroscopy.

## Complications of Anesthetic

Occurrence of a fatal reaction to a topical anesthetic is one of the greatest tragedies in medicine. Since there is no reliable screening test for sensitivity, the attitude is likely to be that these reactions represent an inherent risk in the procedure over which we have no control. Such is not usually the case, however. Anaphylactoid reactions due to idiosyncrasies to drugs are frequently given as an explanation for such reactions. Although it is impossible to say that true idiosyncrasies to drugs may not rarely cause death, certainly in most instances the systemic effect is due to excessively high blood levels of the drug. It has been clearly shown that the blood level of these

drugs after application to the mucous membranes of the tracheobronchial tree resembles that obtained after rapid intravenous infusion.<sup>5</sup> This is, of course, due to the protective physiologic mechanism of extremely rapid absorption of fluid gaining access to the tracheobronchial system and the alveoli. On the other hand, absorption of these agents through the esophageal and gastric mucosa was almost negligible. The systemic effect of a topical analgesic is dependent on the blood level. This, in turn, varies with the amount of the drug and the rapidity with which it is given.

Anesthetic fatalities are almost unheard of in esophagoscopies and gastroscopies, whereas they are not rare in bronchoscopies. Tetracaine hydrochloride is the most commonly responsible agent. The best way to avert an anesthetic reaction is to make certain that the total amount of drug given is in the range of the recommended safe dosage of that particular agent. It is extremely difficult to know just how much of a topical anesthetic is being utilized, and how much is being expectorated, swallowed, exhaled, and retained in cotton pledgets. The one controllable factor is the total number of milligrams of the agent which the patient has an opportunity to absorb. The recommended maximum safe dosage for an adult for cocaine is 180 mg., and, for tetracaine, 40 mg.<sup>6,7</sup>

## Complications of Instrumentation

Complications of instrumentation are due to local trauma, resulting in hemorrhage, or variable degrees of disruption of the wall of the structure. The more anterior position and stronger walls of the trachea and bronchus undoubtedly explain the infrequency of instrumental injury to these structures. A small amount of hemoptysis is not unusual after bronchoscopy, especially if biopsies have been performed.

*Presented at the 110th Annual Session of the Medical Association of Georgia, May 3, 1964, Macon, Georgia.*

*From the Department of Surgery, Ochsner Clinic, New Orleans.*



We have had no instances of bleeding of any consequence. Bronchial perforation results in extravasation of air into the peribronchial tissues and possibly into one or both pleural spaces. Cough and hemoptysis are expected accompaniments of perforation of the respiratory tract; cough, of course, augments the tendency toward extravasation of air. In such instances, tracheostomy may obviate the possibility of building up significant positive pressure. Compromise of pulmonary function from interstitial emphysema, pneumothorax, or both, is a major concern in these cases. There is usually minimal spillage of tracheobronchial contents, and the material is far less infectious than that spilled by esophageal disruption. The following cases illustrate examples of bronchial injury:

*Case One:* A 57-year-old woman had extensive tuberculosis of the right lung. Immediately after bronchoscopy, there was evidence of extravasation of air into the cervical tissues. The diagnosis of interstitial emphysema without pneumothorax was confirmed by roentgenography. Drains were inserted into the superior mediastinum through a low cervical incision with use of a local anesthetic, and the process resolved satisfactorily.

*Case Two:* A 59-year-old man had bronchogenic carcinoma of the left upper lobe. One and one-half hours after bronchoscopy, subcutaneous emphysema of the head, neck, and thoracic wall without pneumothorax developed. Left pneumonectomy was performed immediately and his postoperative course was satisfactory.

There are several plausible explanations for more frequent instrumental injury of the esophagus than of the bronchus. In the first place, its most posterior position makes examination with an unyielding metal instrument more difficult technically, and readily explains the most frequent injury, "pressure split" on the posterior wall at the level of the cricopharyngeus. Moreover, the normal friability of the esophagus is increased by most diseases for which esophagoscopy is indicated. Respiratory compromise due to extravasation of air into the tissues, the pleural space, or both, does occur in esophageal perforation, but is usually less common and important than is the almost universal occurrence of infection. Painful swallowing, in contradistinction to simple dysphagia or difficulty in swallowing, is an early, progressive accompaniment of esophageal perforation. It is the result of a rapidly developing inflammatory reaction in the contaminated tissues. Pain is usually felt in the general region of the perforation. Lateralization of pain suggests pleural soiling, and pain referred to the upper part of the abdomen, in the absence of actual soiling of the peritoneal cavity, is fairly prominent in

lower esophageal perforation. On the other hand, preponderance or limitation of signs and symptoms referable to the peritoneal cavity may occur from perforations into the free peritoneum of a hiatus hernial sac, or from perforation of the terminal esophagus with spillage beneath the diaphragm. Significant hemorrhage is rare after esophagoscopy, there being no cases in the survey report of more than 40,000 esophagoscopies.<sup>3</sup>

We have been fortunate in having no complications of gastroscopy. Perforation is a rare complication, which, according to those having experience with it, is a surprisingly innocuous development for which nonoperative therapy is usually advocated.<sup>3,10,11</sup> High, posterior oblique lacerations through the muscular wall of an empty organ result in a self-sealing type of gastric wound and minimal soiling of the peritoneal cavity. Whether operative or nonoperative therapy is selected would depend, of course, on the clinical course. Illustrative of esophageal injury are the following cases:

*Case Three:* A 55-year-old man, who complained of dysphagia of ten weeks' duration, had carcinoma of the lower third of the esophagus. Esophagoscopy was apparently satisfactorily accomplished but was followed almost immediately by vomiting of about 400 cc. of bright red blood. The biopsy report was squamous cell carcinoma. Through the day, he complained of pain in the chest and back, but showed no signs of shock. Haziness of the lower two-thirds of the right hemithorax was demonstrated in the roentgenogram of the chest taken that evening. At immediate thoracotomy, from 1000 to 1500 cc. of blood was found in the right pleural space, and a large hematoma was seen in the mediastinum. The esophagus was resected from the level of the aortic arch through its abdominal portion together with many involved lymph nodes. The postoperative course was complicated by subcutaneous emphysema, empyema, and mediastinitis with death on the sixth postoperative day. At necropsy a small area of necrosis of the membranous portion of the right lower lobe bronchus, purulent tracheobronchitis and bronchial pneumonia, and infiltrating adenocarcinoma of the stomach were found.

*Case Four:* A 69-year-old woman had had episodes of substernal burning for eight months. A small esophageal hiatus hernia and possible ulceration at the cardioesophageal junction were demonstrated on roentgenography of the gastrointestinal tract. Esophagoscopy was apparently uncomplicated and revealed only slight inflammation of the lower esophagus. The patient complained of progressively painful swallowing beginning as soon as she had recovered from the anesthetic. The possibility of a



perforation was considered seriously enough to begin antibiotic therapy on the second postendoscopic day. On the third day, she was considerably sicker, having a temperature of 102°F. A roentgenogram of the chest was compared with the previous one and revealed splinting of the diaphragm and possibly slight haziness of the upper part of the mediastinum. The cervical region about the larynx was exquisitely tender. At operation with use of a local anesthetic, an abscess containing 3 to 4 cc. of foul purulent material was drained from behind the cricopharyngeal region. The postoperative course was satisfactory.

*Case Five:* A 16-month-old child was admitted nine days after having swallowed a metal toy airplane. This foreign body had been removed at esophagoscopy in his home town; post-esophagoscopy right pneumothorax was treated by needle aspiration. On admission, the child was extremely ill, being unable to swallow and having severe respiratory distress. Tracheostomy was performed initially, after which esophagoscopy was undertaken. Severe inflammatory reaction about the upper esophagus was evident. During esophagoscopy, a communication between the esophagus and some part of the pulmonary system, presumably the trachea, was re-opened. Bilateral pneumothorax was demonstrated roentgenographically. The lungs were reexpanded by use of a closed thoracotomy tube on the left and needle aspiration on the right. The child was critically ill for many days because of empyema due to staphylococcus. After eight weeks, the chest had virtually cleared. The caliber of the esophagus was restored by dilation. The child has developed normally in the ensuing eight years.

*Case Six:* A 66-year-old man complained of dysphagia due to stricture above an esophageal hiatus hernia. Dilation was followed by development of upper abdominal pain, tenderness, and clinical and laboratory evidence of inflammation. Extravasation into the peritoneal cavity was demonstrated on roentgenography after ingestion of lipiodol. At operation, a large abscess of the lesser peritoneal space and the left colic gutter was drained. The postoperative course was satisfactory and dilations were resumed on the seventh postoperative day with establishment of an adequate esophageal lumen.

*Case Seven:* A 58-year-old man had a hiatus hernia and stricture of the lower portion of the esophagus. Esophageal dilation resulted in perforation of the esophagus, which was confirmed by roentgenography after ingestion of lipiodol, with demonstration of extravasation into the mediastinum.

Immediate esophagogastrectomy gave a satisfactory result.

*Case Eight:* A 52-year-old woman returned to the Ochsner Clinic seven years after a Heyrovsky esophagogastrostomy for achalasia of 20 years' duration. During recent months, the dysphagia had gradually recurred. Roentgenography after ingestion of barium showed severe stenosis of the cardio-esophageal region with retained food particles in the dilated esophagus. Esophageal dilation was performed after induction of general anesthesia, and, on recovery from the anesthetic the patient complained of pain in the lower left side of the chest and upper part of the abdomen and abdominal tenderness. Considerable splinting of the chest was demonstrated in the roentgenogram as compared with that of the previous day. The impression was that perforation had occurred. At immediate thoracotomy considerable soiling of the mediastinum from the site of perforation of the esophagus at the stricture was noted. The patient convalesced satisfactorily from resection of a segment of stricture of the lower part of the esophagus and at the cardiac region of the stomach. An adequate stoma has been maintained during the ensuing eight years.

*Case Nine:* A 71-year-old woman complained of dysphagia of four months' duration. A roentgenogram of the esophagus was thought to show the typical "rat tail" type of deformity of achalasia. This impression was substantiated by observations at esophagoscopy and a negative result of biopsy. Accordingly, dilation of the cardio-esophageal region was attempted with the Mosher bag. The patient felt ill during the day, refusing food, and, in the evening, complained of pain in the left side of the chest. The next morning, she was moribund. Roentgenography of the chest showed splinting and haziness of the lower left side. The patient died approximately 24 hours after esophageal dilation. At necropsy, empyema on the left due to perforation of the left side of the esophagus above an infiltrating carcinoma of the upper half of the stomach was noted.

*Case Ten:* A 70-year-old man complained of dysphagia of seven months' duration. The clinical and roentgenographic impression was achalasia. Dilation of the cardio-esophageal region was attempted with use of the Mosher bag under fluoroscopic guidance. This caused considerable pain in the lower part of the chest and upper portion of the abdomen, which persisted after the procedure was completed. On roentgenography of the chest only haziness of the left lower pulmonary field was noted. Esophageal perforation was believed to have occurred. At immediate thoracotomy there was a 4 cm. laceration of the left side of the lower portion of the esophagus



immediately above a tumor, 3 cm. in diameter, which proved to be an epidermoid carcinoma. Esophago-gastrectomy was performed and the postoperative course was satisfactory.

It is tragically demonstrated in our cases, as well as in the literature, that once the diagnosis of perforation had been made, operative treatment probably should be instituted.<sup>2,8-10,12</sup> Whereas no specific rule regarding the necessity for operative intervention in cases of esophageal perforation can be laid down, it would seem that nonoperative treatment should be chosen rarely and only under extenuating circumstances. This is borne out by the higher incidence of fatalities in patients treated by non-operative means as compared with those treated by operation. Patients suffering from esophageal perforation are often acutely ill by the time the diagnosis has been established. In fact, they may be thought to be too ill to undergo an operation, but, on the contrary, they should be considered too ill not to undergo operation. Most deaths from esophageal perforation have been the consequence of sepsis due to a mixed infection of virulent organisms. The type of operation depends on the individual case. This may be simple drainage of the mediastinum or empyematous cavities, attempted repair of the site of perforation, or, as illustrated in four cases herein reported, immediate resection with primary anastomosis.

In summary, injury to the tracheobronchial tree and esophagus during endoscopy is a complication of sufficient gravity to necessitate special attention

during the postendoscopic period. A constant awareness of the possibility of injury and proper handling when it occurs will minimize the ill effects of these unfortunate complications.

#### REFERENCES

1. Palmer, E. D. and Wirts, W. C.: Survey of Gastroscopic and Esophagoscopy Accidents. Report of Committee on Accidents of the American Gastroscopic Society. *J.A.M.A.* 164:2012-2015 (Aug. 31) 1957.
2. Elner, A. and Dahlback, O.: Instrumental Perforation of the Esophagus. *Acta Otolaryng.* 54:279-286 (Mar.-Apr.) 1962.
3. Jones, F. A.; Doll, R.; Fletcher, C. M., and Rodgers, H. W.: Risks of Gastroscopy; Survey of 49,000 Examinations. *Lancet* 1:647-651 (March 24) 1951.
4. Benedict, E. A.: Rupture of the Bronchus from Bronchoscopy During A Paroxysm of Coughing. *J.A.M.A.* 178:509-510 (Nov. 4) 1961.
5. Adriani, J.; Campbell, D., and Yarberry, O. H., Jr.: Influence of Absorption on Systemic Toxicity of Local Anesthetic Agents. *Anest. Analg.* 38:370-377 (Sept.-Oct.) 1959.
6. Weisel, W. and Tella, R. A.: Reaction to Tetracaine (pontocaine) Used as Topical Anesthetic in Bronchoscopy. *J.A.M.A.* 147:218-222 (Sept. 15) 1951.
7. Tella, R. A. and Weisel, W.: Reaction to Cocaine Used as Topical Anesthetic in Bronchoscopy. *A.M.A. Arch. Otolaryng.* 63:115-119 (Feb.) 1956.
8. Nealon, T. F., Jr.; Templeton, J. Y. III; Cuddy, V. D., and Gibbon, J. H., Jr.: Instrumental Perforation of the Esophagus. *J. Thor. Cardio. Surg.* 41:75-104 (Jan.) 1961.
9. Heald, J. H.: Iatrogenic Perforation of the Esophagus. *Calif. Med.* 94:83-87 (Feb.) 1961.
10. Palmer, E. D.: The Risks of Peroral Endoscopy. *U. S. Armed Forces M. J.* 5:974-994 (July) 1954.
11. Calem, W. S.: Perforation of the Stomach During Gastroscopy. *Am. J. Surg.* 103:640-645 (May) 1962.
12. Overstreet, J. W. and Ochsner, A.: Traumatic Rupture of the Esophagus (with a report of 13 cases). *J. Thoracic Surg.* 30:164-180 (Aug.) 1955.

## EMORY SCHOOL OF MEDICINE PLANS M.D.-PH.D. PROGRAM

The Advisory Faculty Council of Emory University School of Medicine has approved plans for a combined M.D.-Ph.D. program. Goal of the program is to provide an improved environment for students seeking to prepare themselves for careers in academic medicine.

Medical school Dean Arthur P. Richardson termed the program "one of the most important new developments in the school."

#### Co-Directors

Dr. James A. Bain, director of the division of basic health sciences, and Dr. E. Converse Peirce II, Associate Professor of Surgery and Physiology, will serve as co-directors of the program.

The faculty committee which explored the feasibility of the combined M.D.-Ph.D. program said there is a definite need for persons with both degrees.

The committee stressed that the combined program "must preserve the quality of both M.D. and Ph.D. degree programs."

The combined program will cover a period of six years following the bachelor's degree. Students will engage in some activity connected with the program each summer quarter. Ordinarily, candidates will be considered for admission into the program between the spring quarter of the freshman year and the beginning of the junior year in medical school.

In the initial phase of the program, three students will participate. The number will be increased to six and a fully activated program will involve 24 students.

#### To Begin Immediately

Based upon the present strength of the faculty, a combined M.D.-Ph.D. program can be started immediately. The program will soon require, however, the addition of two full-time or equivalent part-time faculty members. The fully developed program would require a total of six additional faculty members to give a 4:1 student to faculty ratio.

# TUBERCULOSIS WITHIN THE FAMILY UNIT

Paul A. Pamplona, M.D.,\* *Atlanta*

## ■ *Early and periodic tuberculin testing of children is highly advantageous.*

**I**N YEARS PAST, it was only natural that tuberculosis was considered a family disease. Often many members of the same family died from it, particularly the young, or the entire family was its victim. The progression of disease from parents to children encouraged the belief that tuberculosis was inherited, or at least ran in the family. For rich and poor alike the disease was disastrous. The idea that tuberculosis could be prevented was unknown or unrecognized by those who suffered from it or by those who worked to reduce its ravages.

The belief in inheritance did not begin to give way to the idea that tuberculosis was contagious until after Koch identified the bacillus in 1882. However, we still find people who think the disease is inherited, that it runs in the family.

### **Different Reasons**

Oddly enough, today, we do recognize that tuberculosis is a family disease, but for entirely different reasons. I say this because it is in the family circle, the close continuous contacts of family and friends, that we find tuberculosis. This is readily apparent when we look at a few studies of household groups where a member had tuberculosis.

The Public Health Service made a study of 6,219 households with 25,512 family contacts.<sup>1</sup> On first examination 479 new cases of tuberculosis were uncovered, a rate of 19 per 1,000. Of these, 218 were children less than five years old. In seven South Carolina counties, the examination of 699 family contacts during a two-year period uncovered 62 new cases of tuberculosis; 32 of these were children under five.<sup>2</sup> Similarly, a British Columbia study of 2,043 household contacts disclosed 40 new active cases of tuberculosis, a rate of 19.6 per 1,000.<sup>3</sup> And so the story goes.

Tuberculosis runs in families because parents transmit the disease to their children after they are born. Our children begin life absolutely free from tuberculosis, but it doesn't last long. The risk of developing disease is always greatest within a short time after a person is infected. Every child we allow to be infected with the disease postpones our hopes of getting rid of tuberculosis for another 70 years, the average life expectancy in the United States. For once infected, a person remains at some risk of developing clinical disease as long as he lives. We will never bring control of tuberculosis to the point of eradication if we allow children to be infected. By eliminating tubercle bacilli from the environment of children we take our first step toward eradication.

I do not think however that tuberculosis will be eradicated in the next ten years or in the next 40 years. The disease is too persistent, too complex, and too widespread. World Health Organization estimates point out that tuberculosis kills three million people around the world every year; over 9,000 of these victims are in the United States.<sup>4</sup> Georgia alone had 177 deaths in 1962. If we consider new cases, there are approximately 15 million new cases in the world each year. We had 53,315 in the United States in 1962, and 1,189 of these were in Georgia. I am unable to see why many people think that tuberculosis is not a problem. The misery and expense of the disease are monumental. Yet we can treat it; we can prevent it; even though our tools aren't perfect. We know that recovery can be obtained for 95% or more of all patients excreting drug-susceptible organisms, but we seldom achieve this. We know that diagnosis takes time, even with the best of laboratories. We know that if acid-fast bacilli are demonstrated on direct examination of a stained smear, we still have to culture the organism at least for three weeks in order to distinguish *M. tuberculosis* from other mycobacteria, and that some of these cause disease which cannot be differentiated from tuberculosis clinically. These atypical or un-

\*Chief, Program Service, Tuberculosis Branch, Public Health Service, U. S. Department of Health, Education, and Welfare, Atlanta, Georgia.

Presented at the 116th Annual Session of the Medical Association of Georgia, May 3, 1964, Macon, Georgia.



classified mycobacteria tend to be more prevalent in certain parts of the country than others, and they do not respond well to drugs used in treating tuberculosis. Fortunately their disease incidence is low, but they are important in that they cause cross reaction to the tuberculin test and therefore cause difficulties in diagnosis. Here in Georgia the Battey bacillus, a nonchromogen, has caused considerable trouble for this reason. We know that treatment of tuberculosis is also laborious and prolonged. You can readily understand how difficult it is for a person who feels well to continue treatment for two years. With all these imperfections, we still know what should be done and how it should be done. Our job is to do it.

If we examine the problem, if we look at who has tuberculosis, we can see better how to attack this disease.

#### TUBERCULOSIS IN THE UNITED STATES AND GEORGIA, 1962

##### NEW ACTIVE CASES

Age Group	United States		Georgia	
	Number	Rate	Number	Rate
Under 5	3,020	14.7	93	19.2
5-14	2,965	8.0	103	11.7
15-24	3,752	18.2	97	15.5
25-44	15,313	33.3	313	30.4
45 +	26,599	47.7	567	54.4
All Ages	53,315*	28.7	1,189	29.1

\*Including 666 age not stated for United States and 17 for Georgia.

Of the 53,315 new cases in the United States in 1962, 3,020 were children under five. Of the 1,189 new cases in Georgia, 93 were children under five and 196 were under 15 years of age. We see tuberculosis being carried to a new generation. A five-year old is not likely to get the disease anywhere but within the family, and we can see the importance of the family unit as a major source of infection, as the unit to work with. I would like to discuss a proposal for protecting children from tuberculosis, but first I would like to review some recent concepts about the communicability of the disease and people at risk of developing TB.

Just how contagious is tuberculosis? I hope that we are emerging from the age where a person with tuberculosis was an object of fear. My experience tells me otherwise. The era of the mask and of fumigation are not over. People still panic when they hear about patients being permitted to go home from the hospital for a visit. We still know of instances where patients are chained to their beds to stop them from leaving the hospital.

A diagnosis of tuberculosis does create problems—for the patient, for the patient's family, for society,

and often for the physician himself. We all have to wear blinders in order to get our jobs done, but we must take care not to lose sight of the fact that we are dealing with people who need understanding and help. Certainly reducing the incidence of tuberculosis is a worthy goal, but our methods have limitations. I expect very few patients diagnosed as having tuberculosis like it. In fact, many may object violently, just as you would. They have their fears, their misunderstanding, and their problems. These need resolving. The control of tuberculosis means the control of people's behavior; often-times this means compromise, compromise to achieve our ends and to make sure we aren't getting more unfortunate side effects, like lost patients and drug failures, than the goal is worth.

For a number of years scientists have expressed doubts about the so-called highly contagious nature of tuberculosis and about the hazard of direct or indirect contact with a patient or with contaminated objects. In spite of the fact that tubercle bacilli are sometimes found in dust, researchers have not been successful in infecting animals with such dust under any natural conditions. What are the facts about the contagiousness of the disease? Careful laboratory studies in recent years have uncovered the droplet nuclei mode of transmission.<sup>5</sup> It clearly illustrates how difficult tuberculosis is to transmit. When a person coughs or sneezes vigorously, the strong burst of air tears tiny droplets of moisture from the secretions that line the respiratory tract. If there are tubercle bacilli present, there are torn loose also. The larger droplets rapidly settle out. The smaller ones are barely visible as a fine mist which evaporates quickly and leaves small floating particles of solid residue. These small particles of residue, two to five microns in size, are called droplet nuclei. They will drift like smoke on air currents. Tubercle bacilli may often form the core of these dried droplet nuclei. They are small enough to bypass the muco-ciliary escalator of the larger air passages which ordinarily filter out larger particles of ten microns or more. When a person inhales the droplet nuclei, they can be drawn to the alveoli. Since the alveoli are non-ciliated, the bacillus can be retained long enough to begin its slow growth and start infection.

In several studies with tuberculous patients, the concentration of infective bacilli in the air breathed by patients with positive sputum was approximately one unit of contagion per 12,500 cubic feet of air. This amounts to what might be breathed by a hospital worker during duty hours for one year.

This remarkably low concentration of infective particles in the air is in keeping with the observation that household contacts of people with active tuberculosis usually require prolonged exposure before



acquiring infection. And this infectivity is sharply reduced soon after effective treatment of the case begins.

Examples of the necessity for prolonged close contact with persons with active disease are illustrated in two of the previously noted household contact studies. In British Columbia, out of 766 casual contacts examined, only one case of tuberculosis was found. In the South Carolina study, when 57 contacts of 27 new cases of tuberculosis with negative culture and smear were examined, only three cases of tuberculosis were found. For 80 patients with positive culture and smear, their 215 contacts included 31 new active cases of tuberculosis. The very nature of close household association makes the examination of the family unit where there is tuberculosis the most productive form of casefinding. It also provides us with an opportunity to protect children from the disease.

Another area where our knowledge has grown rapidly in recent years is in that of people at risk of developing tuberculosis. We know that programs for x-raying entire communities uncover few cases of tuberculosis. Such programs amount to useless case-finding. There are more accurate ways to find tuberculosis. We know that people who have inactive tuberculosis are at special risk and should receive first attention. The relapse rate of persons with inactive disease places them in a category of high risk. In addition to the close contacts of active cases already mentioned, we know that people who are reactors and whose chest x-rays show some abnormality should be examined periodically because they are at considerable risk of developing disease, as are people who are tuberculin reactors and undergo stress or sickness, or who are underweight. This kind of information is providing us with better ways to find tuberculosis.

With this knowledge in mind I think we could well direct our attention to protecting children from exposure to tuberculosis. Our special efforts to find cases could be aimed at persons who live or work with children, even though we would find fewer cases than we would, for instance, if we examined homeless men. Homeless men, however, are unlikely to infect children.

An effective way to begin such a program would be to tuberculin test children when they first enter school, or even younger children, and to carefully check out each reactor's source of infection to find where the tuberculosis came from and to find other persons who are likely to develop disease. I know that a child who reacts to tuberculin has already been infected, but this child gives us a clue to the adult who has tuberculosis and who might infect

other children. Children live in a world of children, and families with children associate with other families that have children. Such a program has two great advantages. When a child first enters school, tracing the source of infection will probably not be difficult, and since relatively few children react to tuberculin, the careful examination and follow-up of their associates would be possible for most communities.

In this kind of program, any child who reacted to tuberculin would receive a chest x-ray and the members of the family unit would also be tuberculin tested. Those who reacted would also be x-rayed. The family should be carefully interviewed in case the source of infection is outside the immediate family circle. Plans for the individuals in the family would, of course, depend on what was found. If a case of tuberculosis were found, that person would immediately receive appropriate treatment. The tuberculin reactors would receive a course of prophylactic isoniazid. If no case of tuberculosis were found, the family members would receive attention on the basis of their relative risk. The children under four who were tuberculin reactors would be given a year of isoniazid prophylaxis. Other members of the family whose x-rays were suggestive of tuberculosis would receive frequent examinations and in some instances treatment. Another aspect of this program to protect children would be tuberculin testing and x-raying people whose occupations place them in contact with young children. This includes teachers, school employees, babysitters, and employees of day-care centers.

The general practitioner and the pediatrician can contribute to such a program by being more aware of the possibility of tuberculosis and by testing for it. Where there are tuberculous adults there may be infected children and vice versa.

Wherever children are given high priority, our journey to eradication begins. All that is needed for the journey is available. We must function not only as physicians but also as public minded citizens intent on securing for every child the right to be protected from a preventable communicable disease.

## REFERENCES

1. Ferebee, Shirley H., and Mount, Frank W.: Tuberculosis Morbidity in a Controlled Trial of the Prophylactic Use of Isoniazid Among Household Contacts, *Am. Rev. Resp. Dis.*, Vol. 85(4): 490-510 (1962).
2. Geiger, Frank L., and Kuemmerer, Janie M.: Tuberculosis Case-Finding Among Contacts in Seven South Carolina Counties, *Pub. Health Rep.*, Vol. 78(8), pp. 663-668 (August 1963).
3. Division of Tuberculosis Control, Health Branch, Department of Health Services and Hospital Insurance: Province of British Columbia—Annual Report for the Year 1962.
4. Tuberculosis Program, Communicable Disease Center: Report Tuberculosis Data, 1964 edition.
5. McLean, Ross L.: How Contagious is Tuberculosis *NTA Bulletin*, December 1963.



# WELL BABY CARE: UNTAPPED PORTAL OF ENTRY TO FAMILY CARE

Caroline A. Chandler, M.D.,\* *Bethesda, Maryland*

■ ***The comprehensive or total approach to the child and his family should now be the order of the day.***

**R**OUTINE CARE of the well baby is standard practice today whether given by private pediatricians, general practitioners or in public health well baby clinics. This routine care, or health supervision, too often consists of a hasty physical examination or inspection and a "shot" interspersed with a few words tossed at the mother regarding feedings, vitamins and what not—all in a "visit" of five minutes or less!

It is my firm conviction, based on experience in both private and public settings that a golden opportunity to gain access to family practice is being lost by this perfunctory type of well baby care. If well baby care were seen as a "portal of entry" into the physical and mental health care of the whole family, then this kind of service would be replaced with the kind of high quality medical care and counselling that we, as physicians, are now capable of delivering.

I have no intention of getting into the controversial area of why this kind of lip service to well baby care is still very much the order of the day in many places at the present time. I believe this would serve no useful purpose. Instead, I should like to look at this whole topic in terms of four questions.

These questions are: 1) where have we come from?; 2) where are we now?; 3) where do we go from here? and 4) where can we plow new fields?

To take up the first question:

## **Where Have We Come From?**

For 30 years the well baby clinic has stood on the threshold of implementing a concept of preventive intervention with the pre-schooler and his

parents around problems of emotional growth and development as well as physical growth and development. As far back as the early 1930's Dr. Leo Kanner<sup>1</sup> set up the first combined psychiatric-pediatric clinic in the Harriet Lane Home of The Johns Hopkins Hospital. Ever since, sporadic attempts have been made to combine periatric-psychiatric and public health practices toward the care of children and their families. In the late 1940's and early 1950's attention was drawn to the needs of the "whole child" and his family. Repeated pleas during that time were made that the well baby clinics should be seen as providing an opportunity for the pediatrician, the public health nurse and the mental health specialist to combine their mutual skills, to provide the best kind of physical and emotional health supervision for babies or children and their families.

No less a person than Dr. Leona Baumgartner, the former Commissioner of Public Health for New York City, was one of the most ardent supporters of this kind of integrated service. As a matter of fact, Dr. Baumgartner was one of the participants in the now-famous Conference that took place in Berkeley, California, in July, 1948. It was out of this Conference that the book emerged entitled *Public Health is People*.<sup>2</sup> On Page 86 of *Public Health is People* there is a quotation that runs this way; "It seems to me that a community mental hygiene program ought to begin in the well baby clinic. We don't see all the babies in our communities but those we do see could get a better start in life if we applied what we have learned here to our child health services."<sup>2</sup>

In 1959 Dr. Charles May reiterated this theme when he coined the term "the new pediatrics"—and he defined the new pediatrics as having to do with comprehensive care of the child in relation to his family.<sup>3</sup> He also suggested that the trend was away from the strictly limited organic approach

\*Chief, Child Mental Health Section, Community Research and Services Branch, National Institute of Mental Health, Bethesda, Maryland, and Assistant Professor of Pediatrics, The Johns Hopkins University School of Medicine, Baltimore, Maryland.

Presented at the 110th Annual Session of the Medical Association of Georgia, May 3, 1964, Macon, Georgia.

toward the comprehensive or total approach to the child and his family. So much for where we came from—.

The next question is:

## Where Are We Now?

I shall now present some of the material that has emerged from surveys of well baby clinic or child health conference practices. I am using data obtained from clinics because it is extremely difficult to obtain sufficient data on child care practices by private physicians to permit valid statistical analysis. I should like to remind you, lest perhaps you think I am too public health minded, that the majority of well baby clinics are manned by private pediatricians or general practitioners.

In a survey of well baby clinics, conducted in Baltimore, in 1962 and reported in the 1962 edition of the book *Preventive Medicine* by Dr. Paul Harper, it was found that four minutes were spent with the doctor, including "hello" and "goodbye." The total time varied from two to ten minutes. In an earlier survey carried out by Dr. Blum in similar type clinics in New York City, the average time spent with the doctor was closer to five minutes with a range of 1.5 to 19.5 minutes.<sup>5</sup> In the most recent study, a survey of Well-Child Conference Stations in New York City was carried out by Dr. Harold Jacobziner and his colleagues. The results of this survey were reported in the December 1963 issue of the *American Public Health Association Journal*, under the provocative title: "How Well Are Well Children?"<sup>6</sup> Since this study is one of the most complete and provides some of the best answers to the question—where are we now—I thought it might be timely to quote significant findings from the summary of that paper.

"Data are presented on 22,873 children examined in New York City Well Child Conferences in 78 child health stations. Thirty-nine percent of all children examined had one or more adverse health conditions. A total of 10,615 defects were found in 8,865 children or an average of 0.5 per child for the total group and 1.20 adverse health conditions per child for the group with medical disorders. Three hundred and fifty-five distinct clinical entities were discovered during the study period. These were classified into 23 major groupings. Of all adverse health conditions found, 48 per cent were newly discovered during the survey. Variations were noted by age, color and sex. The frequency of adverse health conditions is higher in the under 18-month old, in the male, and the nonwhite. Respiratory illness was the most commonly diagnosed condition. Next in

frequency was "skin allergy." No significant differences by ethnic group were observed for emotional and behavioral conditions or in the incidence of "trauma and accidents."

"Feeding difficulties" was the leading diagnosis in the emotional and behavioral category and overnutrition, rather than undernutrition, in the nutritional category.

Congenital malformations were much higher in the white, and genitourinary conditions were strikingly higher in the Puerto Rican.

A significant proportion of infants and children receiving well child supervision and presumed to be well are actually presenting evidence of some disorder requiring medical care. In the low socioeconomic groups, it is important to provide preventive and curative services to avoid delay in treatment, unnecessary referral to overcrowded hospital clinics, and an inconvenience to patients and families. Several plans for initiating such services are outlined.

The child health conference is an excellent device for finding children with a health problem. An important and often overlooked aspect is the need for providing immediate necessary medical care and where indicated follow-up. There is little use in devoting a great effort to merely finding a child with a health problem unless something is done to insure that the infant and/or child receives needed medical care promptly.

Thus, even if treatment is not provided as part of the well child conference, the public health nurse has a duty and an obligation to motivate and advise the family in obtaining the indicated care. This may be done by home visits and conferences. In all cases, the medical treatment regimen and outcome should be reported in detail in the child's medical record.

The physician working in the child health conference must be well trained in pediatrics, a skillful diagnostician and deeply concerned with the health and welfare of children. The well child conference of the future must provide integrated, comprehensive, high-quality, family centered services, both preventive and curative."<sup>6</sup>

Next we come to the third question:

## Where Do We Go From Here?

In answer to this question, I think we have to make a choice. Are we going to follow the same old, traditional hoe and shovel cultivating and harvesting of babies—or are we going to make use of modern, scientific tools or, what I would like to call, "combines" available to us. Under these "combines" I would include new diagnostic procedures, laboratory techniques and a wealth of consultation and supporting services. To name just a few of the latter, I would include consultation from various other specialists—such as the surgeon, the neurologist, the



dermatologist, the psychologist, the psychiatrist, the ophthalmologist, the radiologist, the dentist, the orthopedist. Among supportive services, I would include the services of the nurse (public health or otherwise), the social worker, the nutritionist, the medical technician, the volunteer and so on. With regard to supportive services, I should like to emphasize one point which, I believe, is vitally important. I've had many practitioners say to me—" . . . but, Doctor, I can't afford to have a nurse or a social worker or a nutritionist as part of my office armamentarium—I'd go broke,"—to which my answer always is "Sure, you'd go broke, but who is suggesting that you have to staff your office with such skilled but scarce professionals? What I *am* suggesting is, first, that you know how to make the best use of other professional skills and, second, that you know where to find them. . . ." In my experience, many of my colleagues haven't the vaguest notion of what a community has to offer, in the way of community services, both public and private. Most physicians, of course, are aware of the local health department and have had occasion to consult with the health officer or ask for a home visit from the public health nurse. But how many of us know, or take the trouble to find out, the full range of services the health department can provide to us for our patients? And if this is so for an agency as close to us as the health department, what do we know about the services available to us through the welfare department? (for casework service); the Board of Education (for a home teacher); the Vocational Rehabilitation Department (for a rehabilitation worker); the Courts and Probation? And what about the voluntary community agencies? The family service agencies (for family counselling and casework); the Health and Welfare Council—for information and referral service); the Legal Aid Society (for legal counselling); Alcoholics Anonymous (for help with alcoholics)?

When I was a medical student I lived in a constant state of anxiety, bordering on despair, at the thought of all the things I was supposed to know—about anatomy, pathology, bacteriology, medicine, surgery, gynecology, psychiatry, neurology—to name only a few! I used to think—how can a single person not only learn the fundamentals, but keep abreast of new developments in so many diverse fields. One day I spilled over and poured my heart out to a sympathetic professor of medicine. He heard me out at length and then said, very simply: "There is only one thing you have to learn to be a good doctor: the secret is not to know all the answers but to know *where to find them*." That was the most important lesson I ever learned in my entire medical career.

To bring the foregoing in line with our topic of well baby care, I think what I am suggesting is that if we really want to use well baby care as a portal of entry to family care, it behooves us to know where we can find the answers. Or to put it in more practical terms, it behooves us to know, or to find out, where we can get help from our colleagues and from the various community agencies in order to offer the kind of family care we, in this super-jet atomic age, are capable of delivering.

I would like now to tackle briefly the fourth (and last) question:

### **Where Can We Plow New Fields?**

We are faced with a multiplicity of possible fields to plow—and must, therefore, make choices. For this reason I will mention only one field which is relevant to the area we have been discussing, but which I happen to believe is of vital importance.

In 1962, Congress approved an amendment to the Social Security Act authorizing up to \$10,000,000 annually to the States for the provision of day care services for children in facilities licensed by the States. This was the first time that the federal government earmarked funds for a specific part of the child welfare section of the Social Security Act. This legislative action by Congress represented recognition of the fact that working mothers are here to stay and that their children require better care than the casual arrangements or unsupervised foster care many of them are getting today.

In anticipation of this legislation, the American Public Health Association, some two years ago, established a Day Care Committee and charged it with developing guidelines and preparing a handbook on day care services for children.

On the governmental level, the DHEW assigned responsibility for the development of standards for day care services to the Children's Bureau. These two national agencies, one private and one public, took on the responsibility for being the standard bearers in this new and vitally important field concerned with the health and welfare of children. Regardless of the quality of the guidelines and recommendations these standard setting bodies may provide, the kinds of programs they propose will come into being *only if we, the rank and file plowers, join forces to man the "combines."*

### **Conclusion**

When I finally got around to finishing my homework for this discussion with you, it suddenly occurred to me that I ought to take a look at what I had promised to do in the abstract printed in the March issue of the *Journal of the Medical Association of Georgia*. The final sentence read "The author will



suggest some ways of utilizing this portal of entry and give examples based on her own experience." Only then I remembered that I had planned to present a few of my own case reports which would illustrate the well baby portal of entry theme in terms of the various specialty groups you represent. Like, for example, the wife of a medical student at Johns Hopkins who brought her baby to the well baby clinic I ran for staff dependents. She assured me that she brought her baby in for routine immunizations only. It was during some vague, reassuring remarks of mine about the baby's possible reaction to the second DPT shot that she floored me by saying "Doctor, can you help me? I'm afraid my husband is trying to commit suicide." You can imagine how quickly I moved into this portal! Or like the time one of the mothers of a small group of patients I look after where I live arrived on my doorstep. In high dudgeon she complained that her children had just come down with pinworms and she was sure they had picked them up from Susie or Jamie down the road and she wanted to know what I was going to do about this public health hazard! The fact that this woman was currently feuding with the mother of Susie and Jamie didn't help a bit because this completed the roster of mothers who had come to me individually blaming the pinworms on the children of all the neighbors they weren't speaking to. This left me stuck with persuading all 12 families on Wagon Wheel Road to take piperazine simultaneously!

The case report I should like to cite in conclusion comes not from my files but from one of the biographies of Sir William Osler.<sup>7</sup> To me the following story about Osler captures in one brief paragraph the essence of the art of medicine as practiced by "The Great Physician—The Master and lover of men."

"Did you know Dr. Osler?" some one asked another, 'Yes,' was the answer, 'intimately, but I only saw him once. It was late twilight; the city square was almost deserted when a woman

carrying a heavy child came slowly up the center of the square and sat down to rest on the coping that separated the pavement from the grass. The child's heavy head was pressed against her bosom and she seemed all in. I started to speak to her when up the square came jauntily along a man in full evening dress, in top coat, silk hat, flower in his button hole, light gloves in one hand and his cane deftly swinging in the other, evidently singing. In an instant he saw the woman and her burden. He stopped, made a playful drive with his cane at the child, then throwing cane and gloves on the grass, he gently lifted the child into his arms holding its head against his own breast as he talked to the mother, then whistling to a little boy who chanced in sight he said: 'Get a cab as quick as you can and if you are back in five minutes, riches! for you!' and he patted his breast pocket. The boy flew off and was back in record time with the cab. The Good Samaritan put the woman in the cab, carefully placed the child on her lap—then he wrote on a card, 'This is Mrs. Osler's youngest. See that he is well taken care of until I come tomorrow night.' He read what he had written aloud to the woman, winked his eye at me, gave the driver his fare, told him to drive at once to the Hopkins Hospital, see that the woman and boy were safely attended to—then pressing a five dollar bill in the woman's hand, said: 'Your laddie will be well looked after at the hospital. I will see him tomorrow. You go to your home and get drunk,' slammed the door of the cab and was off. All done while I was trying to say, 'Can I help you?'"

## REFERENCES

1. Kanner, L.: The Development and Present Status in Pediatrics, *J. Pediat.*, 11:418, 1937.
2. Ginsburg, E. L.: *Public Health is People*, Cambridge, Harvard University Press, 1950.
3. May, C. D.: Can the New Pediatrics be Practiced? *Pediatrics*, 23:253, 1959.
4. *Child Health Conference: in Preventive Pediatrics*; edited by P. A. Harper, New York, Appleton-Century-Crofts, 1962.
5. Blum, L. H.: Some Psychological and Educational Aspects of Pediatric Practice: A Study of Well-Baby Clinics. *Genet. Psychol. Mono.* 41: No. 1, 1950.
6. Jacobziner, H., et al: How Well are Well Children? *Amer. J. Public Health*, 53: 1937-1952, 1963.
7. Reid, E. G.: *The Great Physician*. New York, Oxford University Press: 136-137, 1931.

## EMORY MEDICAL ALUMNI DAY

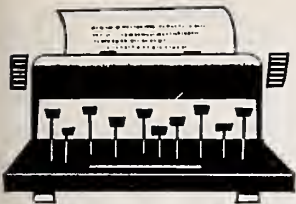
Announcement is made that Monday, April 12, 1965, will be Emory Medical Alumni Day. All alumni are invited to attend and are requested to register for the luncheon and dinner dance as early as possible with the Alumni Office.

The Day's schedule is as follows:

- 9:45 a.m. Grand Rounds at Grady Memorial Hospital Auditorium—Dr. Paul Beeson
- 12:00 Noon Luncheon and Business Meeting at Cox Hall on the Emory Campus (Food Service Building)

- 1:00 p.m. Address in the Emory Hospital Auditorium by Dr. Paul Beeson on "PYELONEPHRITIS"
- 2:00 to 5:00 p.m. Guided Tours of Hospital and School by medical students
- 2:00 to 5:00 p.m. Golf, arranged by Dr. Richard Margeson
- 6:30 Social Hour—Piedmont Driving Club
- 8:00 p.m. Dinner and Dance—Piedmont Driving Club





## Welcome to Augusta

**T**HE GREAT CITY OF AUGUSTA, Georgia, welcomes fellow members of the Medical Association of Georgia for the 111th Annual Convention. Augusta, by its popular name known as the Golf Capital of the World, can be accurately described as a city of progress. It's fast becoming known to many thousands as a medical, military, cultural, industrial, and sports center.

This city of quaint old Georgia history is rapidly expanding in every respect, boasting of the Medical College of Georgia and its four affiliated hospitals; Fort Gordon with its thousands of military personnel; the constant arrival of new industry which has picked Augusta as home because of its abundant water and power supply, and its pleasant climate and friendly atmosphere.

### A Growth in Culture and Education

While industry has shown much progress, there has likewise been a fine growth in the cultural and educational facilities of this entire section. Augusta College is now a four year institution, and new and beautiful library facilities make Augusta equal to

cities of greater size. Civic leadership takes great pride in the efficiency of city and county governments and there is a spirit of community teamwork among citizens of this area that foretells a continuation of growth at all levels.

Our new International Raceway, eight championship golf courses in the immediate Augusta vicinity, and Clark Hill Lake, with its more than 1200 miles of shoreline offering year-round boating, swimming, waterskiing, fishing, hunting and camping facilities, are only a few of Augusta's recreational offerings. All of these factors go into making Augusta an ideal place to live, to work, and to play. Make your plans to attend the M. A. G. Convention at the beautiful new Augusta Town House, site of convention headquarters May 2-4, 1965. This city opens its arms of welcome to one and all of you and I hope you will have the greatest time ever, both professionally and socially.

See you in Augusta!

*Cecil A. White, Jr., M.D.*

*President*

*Richmond County Medical Society  
Augusta, Georgia*

## AMA Delegates Special Session

**M**EETING in a two-day special session to consider current health care legislation pending in Congress, the House of Delegates of the American Medical Association gave unanimous approval and support to the AMA Eldercare program embodied in the Herlong-Curtis bill (H.R. 3727).

In acting upon seven resolutions at this February 6-7, 1965 session, the House of Delegates also:

(1) Reaffirmed its opposition to the King-Anderson bill (H.R. 1) and all similar measures;

(2) Commended the AMA Board of Trustees and its Task Force for implementing and funding

a program of public education on the AMA Eldercare program;

(3) Called for a study of the "desirability and feasibility of extending the principle of federal-state aid under the Kerr-Mills principle to persons below age 65 who need help";

(4) Adopted a statement on Standards for Health Care Programs, and

(5) Urged that the professional services of pathologists, radiologists, anesthesiologists and psychiatrists should be excluded from the provisions of any bill which excludes other physicians' services.

In a keynote address to the House, AMA President Donovan Ward condemned the King-Anderson bill and urged support of the AMA Eldercare bill. Dr. Ward told the House:

"Are 200,000 doctors wrong in urging the Congress to give serious consideration to the one measure now before it that offers genuine medical and hospital benefits to the needy aged? This is a bill authored by neither the Republican party nor the Democratic party. It is a bill with bipartisan parentage—the Herlong-Curtis Eldercare bill numbered H.R. 3727. We urge Congress to compare, and the people to compare, this bill with its genuine benefits and realistic financing—and with its provisions allowing for administering a health program through

health agencies of the state—to compare it feature-by-feature with Medicare.

"If the drums can be stilled long enough to make this comparison, it will be found that the Herlong-Curtis Eldercare bill can cover not only the cost of hospital care and nursing homes for the aged, but also the payments of physicians and surgical and drug costs—which Medicare would not do."

Dr. Ward declared that "it is never too late to pass good legislation and defeat bad legislation. The one thing in this historic decision—the only thing—that may truly come too late, is regret."

President Ward closed his address with this question: "I will ask you who sit in this highest house of medicine . . . I will ask those who sit in our houses of Congress. I will ask our patients, the American people—Are 200,000 doctors wrong?"

## LUNG SEMINAR TO BE PRESENTED IN CONJUNCTION WITH ANNUAL SESSION

A Seminar on Chronic Obstructive Lung Disease, May 1-2, 1965, Augusta, Georgia will be presented by: THE GEORGIA THORACIC SOCIETY, THE GEORGIA TUBERCULOSIS ASSOCIATION, THE MEDICAL COLLEGE OF GEORGIA, and THE GEORGIA ACADEMY OF GENERAL PRACTICE—with financial assistance from: ASTRA PHARMACEUTICAL PRODUCTS, INC., BIRD CORPORATION, LINDE CORPORATION, MERCK, SHARP & DOHME POSTGRADUATE PROGRAM, and MEAD JOHNSON & CO.

**FACULTY:** GUSTAV J. BECK, M.D., Instructor, Columbia University College of Physicians and Surgeons; Director, Pulmonary Laboratory, St. Clare's Hospital, New York, N. Y.

BEN V. BRANSCOMB, M.D., Associate Professor of Medicine and Director, Division of Pulmonary Disease, University of Alabama Medical College, Birmingham, Ala.

CURTIS H. CARTER, M.D., Professor of Medicine and Chief, Pulmonary Division, Medical College of Georgia, Augusta, Ga.

ROBERT G. ELLISON, M.D., Professor of Surgery and Chief, Thoracic Division, Medical College of Georgia, Augusta, Ga.

WILLIAM F. MILLER, M.D., Associate Professor of Medicine, University of Texas Southwestern Medical School; Director, Pulmonary Function Laboratories, Parkland Memorial Hospital, Dallas, Tex.

HARRY B. O'REAR, M.D., President, Medical College of Georgia, Augusta, Ga.

JOSEPH C. ROSS, M.D., Associate Professor of Medicine and Director, Pulmonary Disease Division, Indiana University School of Medicine, Indianapolis, Ind.

LESTER RUMBLE, JR., M.D., Director, Albert Steiner Memorial Clinic, St. Joseph's Infirmary, Atlanta, Ga.

GERALD P. SHELDON, M.D., Chief, Inhalation Therapy Service, Presbyterian Medical Center, San Francisco, Calif.

### PROGRAM

Saturday, May 1

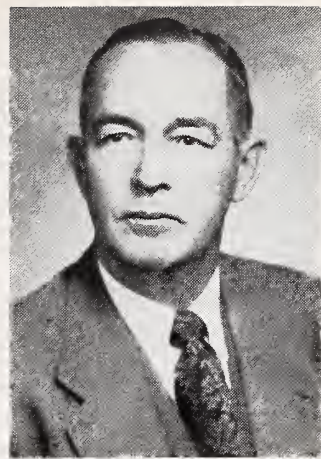
- 9:00 Registration—Lobby, Educational Building  
Dr. Lester Rumble, Jr., presiding
- 9:50 Welcome—Dr. Harry B. O'Rear.
- 10:00 ETIOLOGY OF AND STRUCTURAL  
CHANGES IN CHRONIC OBSTRUCTIVE  
PULMONARY EMPHYSEMA—Dr. Joseph  
C. Ross.
- 11:00 USES OF MOISTURE AND MUCOLYTICS  
IN THE THERAPY OF CHRONIC OB-  
STRUCTIVE LUNG DISEASE—Dr. William  
F. Miller.
- 12:00 Lunch (ad libitum).
- 1:30 THE ROLE OF CORTICOSTEROIDS IN  
THE TREATMENT OF CHRONIC OB-  
STRUCTIVE LUNG DISEASE—Dr. Gustav  
J. Beck.
- 2:30 MECHANICAL VENTILATORS—Dr.  
Gerald P. Sheldon.
- 3:30 Coffee.
- 3:50 EXERCISE AND OXYGEN THERAPY—  
Dr. Ben V. Branscomb.
- 6:30 Meet the Speakers—Social Hour,  
to Georgian Room, Augusta Town  
House Motor Hotel, 744 Broad.
- 7:30

Sunday, May 2

Dr. Curtis H. Carter, presiding

- 9:30 Questions and Panel Discussion—  
to Drs. Beck, Branscomb, Ellison, Miller,  
11:30 Ross and Sheldon; Dr. Carter, moderator.





## LET GEORGE DO IT — OR MARY

Sometime ago I read in the editor's column in *The Times Journal*, a weekly Dodge county paper, a letter written by a man by the name of Chet Shore, from Montana. His letter impressed me tremendously, since it applies to so many of us in our profession. While I can't quote him verbatim, I can give the gist of what he said. He did not include Mary, but I am taking the liberty to do so—in addition to adding a few things.

My name is George, so he said, and I have a wife by the name of Mary. We have no children, no close family ties. We are not too enthusiastic about anything in this life more than a good bed and a fairly good meal two or three times a day. We are not much interested in worldly goods.

Again, my name is George and my wife's name is Mary, and I would like for you to feel free to use our services for any or all of those chores, errands and duties that you may be too busy to perform—why not let good old George, or my wife Mary, do it?

We'll write your congressman or legislator for you. We'll write your letter to the editor of the newspaper. We'll go to the PTA, serve on the Board of Education or the City Council for you. We will do anything that you are too tired or preoccupied to do. With us around you can be as charming as you like; you can have lots of fun, play golf, go fishing, travel, attend the movies, a fashion show, or enjoy parties at the club. All those nice things.

Me, ole George, and my wife, Mary, are available for all those tedious and time consuming things that you like to shy away from. We'll even vote for you; you need not take the time to go to the polls. We will serve on all the committees you dislike. Mary will gladly take your place on the Republican Committees and ole George will do his best on the Democratic Committees. You and your wife go ahead and have a real good time.

You might ask, "Why are we—old George and my wife, Mary, so interested in taking on all these jobs?" Well, you see we are not beginners, we've been around for a long time. For generations it's been "Let old George do it—or let Mary do it." We are not very famous, but if it hadn't been for people like us there never would have been a Mussolini, Stalin or Hitler. There would never have been any big time racketeers, nor would there ever have been any crooked politicians dictating the policies of cities and influencing our national government.

We like to run errands for you because we get a big charge out of electing presidents of school boards and seeing presidents of great universities fired. We get a kick out of stirring up discord in the professions such as religion, medicine, politics, law and education. All the troubles you used to iron out before they got started, until you got so busy exploring ways to corner a dollar and spend it. We enjoy the power you give us. We're not too enthusiastic about money at this time, anyway.

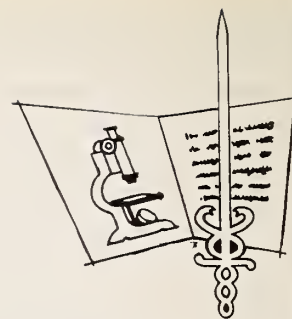
Now don't feel like you're imposing on "ole George and my wife, Mary." We're glad to be of service to you. You see, we would like to run this country today, and pretty soon, rule the world. Just say "let George do it" or "let Mary do it," and we will. Gladly.

In conclusion, we would like to thank you. Remember if we can pinch hit for you, we are at your command—don't worry, have fun!!

WE'LL BILL YOU LATER!

A stylized, cursive signature of J. G. McDaniel.

J. G. McDaniel, M.D.  
President, Medical Association of Georgia



## THE CURRENT STATUS OF REGIONAL PERFUSION IN THE CHEMOTHERAPY OF CANCER

Harold S. Engler, M.D., *Augusta*

FOLLOWING the initial experience in the perfusion of isolated areas of the body with cancer chemotherapy agents, there was a wave of enthusiasm for this method of treatment. Certain chemotherapeutic agents had been known to be effective against malignant cells for many years (for instance nitrogen mustard in Hodgkin's disease), but delivering the agent to the tumor by its arterial supply was not seriously considered until Kloop published his experience (*Annals of Surgery*, 1950). With the development of the pump oxygenator for open heart work, it became evident to the Tulane Surgical Faculty that chemotherapeutic agents in higher dosages might be confined to the tumor-bearing area with appropriately placed tourniquets of a temporary extracorporeal circulation. It seemed reasonable that higher dosages might have much greater effect upon the cancer and that the usual systemic toxic effects could be avoided.

### Considerable Experience

Techniques have now been developed for perfusing almost all regions of the body and considerable experience has been accumulated. Knowledge of the perfusion of isolated areas, tissue toxicity of drugs, and the effect upon tumors by increase concentrations has resulted. With this technique much basic information also has been gathered regarding the biochemistry of the perfusate and physiology of the perfusion system. The flows and pressures required, the isolation and monitoring of the agent, and the drugs most applicable have been standardized.

Although techniques have been worked out for many regions, some lend themselves to isolation perfusion more than others. For example, the extremities can be perfused with less expected drug escape than the perfusion of head and neck or such organs

as the brain, liver, or lung. Total abdominal perfusion and total pelvic perfusion have presented special problems in isolation. However, data on treated patients in all of these categories have been accumulated, and the results on a large number of patients are now known.

### Selection Is Important

The results have indicated that selection of patients is most important. Although some institutions continue clinical investigation in evaluating regional perfusion as an adjuvant to curative surgical therapy, palliative treatment is usually the prime objective. Even so, every patient with recurrent or disseminated disease is not a candidate. Only a small percentage of such patients may obtain benefit, and then usually for only a short period of time. The patients selected should be those in whom definite palliation is needed and those who have advanced malignancies which cannot be controlled by irradiation or resection. Patients who need relief of pain, healing of ulcerations, or reduction in bulky masses may be candidates particularly when the site of the lesion allows the prospect of good isolation of the agent from the systemic circulation. In general, patients considered suitable for therapy are those with certain types of cancer for which known agents have been shown to be of practical value (for instance alkylating agents for melanoma), those whose disease is not preterminal cancer, and those in whom progression of disease is associated with symptoms and increasing disability that cannot be controlled by usual means. There is no justification for submitting an asymptomatic patient to this form of therapy on the grounds that such treatment may delay recurrence and hence prolong life.

*Talmadge Memorial Hospital*

Approved by the Professional Education Committee, Georgia Division, ACS.





## CARDIOVASCULAR ANOMALIES OF MARFAN'S SYNDROME

Henry Randall, M.D., *Marietta*

**T**HE GENERAL manifestations of Marfan's syndrome are well described in standard textbooks. This discussion concerns itself with the cardiovascular disorders of the syndrome. Of over 400 cases reported cardiovascular anomalies were found in 30% to 60%.

The disorder of connective tissue responsible for the major cardiovascular anomalies involves elastic tissue, smooth muscle, and ground substance. The most common and interesting disorders are found in the aorta. Here the major involvement occurs at the base and infrequently goes beyond the origin of the innominate artery. The aortic ring and adjacent intrapericardial portions of the aorta are the first areas affected and may not be associated with the usual x-ray changes of ascending aortic aneurysm. The pulmonary conus and artery may be displaced and lead to x-ray changes erroneously indicating pulmonary artery disease or disorders with increased pulmonary flow such as septal defects.

Steinberg first demonstrated with angiocardiography greatly dilated aortic sinuses which may be the earliest findings. Retrograde aortograms now demonstrate this in even greater detail.

### Aortic Cusps

The aortic cusps are frequently involved and become enormously stretched, adding to the aortic regurgitation already present secondary to dilation of the aortic ring. Stretching may proceed to the point of fracture, producing wide-open aortic insufficiency, associated with its "cooing dove" murmur. Aortic regurgitation in Marfan's, associated with angina, bears the same poor prognosis as when associated with Rheumatic and Syphilitic aortic insufficiency. Most succumb within two years of onset. Myocardial infarction is reported in instances of dissection involving ostia of coronary arteries.

Dissecting aneurysm is the result of the same defects responsible for dilation. It is indistinguishable from cystic medial necrosis of dissection not associated with Marfan's. Almost all cases occur in the proximal portions of the aorta and the dissection is frequently the mechanism of producing aortic regurgitation. It is noteworthy that dilation of the aortic ring, aortic aneurysm, and dissecting aneurysm frequently coexist. Lesions similar to those found in the aorta may be present in the pulmonary artery, but they are rare.

The incidence of septal defects was emphasized in early reports. More recent reports still show an occasional instance of atrial septal defect, and two reports of concomitant tetralogy of Fallot are found.

The pectus excavation deformity is frequently associated with dyspnea which is apparently pulmonary in origin, and related to decreased chest excursion. Atrial arrhythmias are commonly found and are apparently related to a shift in cardiovascular structures by the deformed sternum.

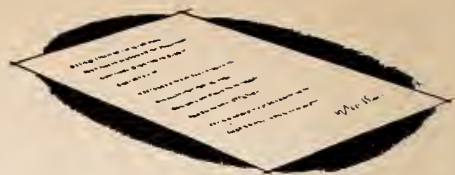
The forme fruste type of Marfan's, with the classic external features absent or less conspicuous but with serious cardiovascular anomalies, is occasionally encountered. For this reason, the possibility of Marfan's disorder should be considered in cases of thoracic aortic aneurysm and aortic insufficiency, especially in the young patient without a clear cut history of rheumatic fever. Retrograde aortography in such instances might be helpful if aneurysm of the aortic sinuses is demonstrated. This seems especially relevant in view of the increasing use of valve prosthesis and the likelihood that the defective tissue would fail to hold a prosthesis.

1308 Church Street

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.



# ABSTRACTS BY GEORGIA AUTHORS



**Paulk, E. Alan, Jr., M.D. and W. Edmund Farrar, Jr., M.D., 80 Butler Street, S.E., Atlanta 3, Georgia, "Diverticulosis of the Small Intestine and Megaloblastic Anemia," A. J. Med. 37:473-480 (Sept) 64.**

Diverticulosis of the small intestine is sometimes associated with the development of a malabsorption syndrome. This is in part characterized by defective absorption of vitamin B<sub>12</sub> and megaloblastic anemia with or without steatorrhea and other defects. Proliferation of coliform organisms in the stagnant areas is thought to play a role in the pathogenesis of this syndrome.

In the case presented, culture of fluid from the distal duodenum revealed large numbers (30 million per ml.) of an unusual strain of *Escherichia coli*. After a brief course of tetracycline therapy, the number of organisms remained unchanged, but the strain isolated was resistant to tetracycline and had certain other biochemical differences. Marked improvement in absorption of vitamin B<sub>12</sub>, D-xylose and triolein followed the antibiotic therapy. Both strains of *Esch. coli* were able to extract vitamin B<sub>12</sub> from culture medium very avidly. Six months later, absorption of vitamin B<sub>12</sub> was again abnormal and at this time a mixture of the two strains previously isolated was found in the distal duodenum.

These findings seem compatible with the hypothesis that certain organisms elaborate products which are capable of inhibiting intestinal absorption.

**Hartrampf, Carl R., Jr., M.D., 1938 Peachtree Road N.W., Atlanta, Georgia, "Management of the Burned Hand," South M.J. 57:1342-1345 (Nov) 64.**

The permanent crippling in many patients with deep burns involving partial thickness of the skin of the dorsum of the hand can be prevented by judicious early excision and grafting. The advantage of this procedure is reduction in healing time and preservation of the delicate function of the interphalangeal joints. The basic features of this technic are described in the article.

**Torpin, Richard, M.D., Medical College of Georgia, "Amniochorionic Mesoblastic Fibrous Strings and Amnionic Bands," Am. J. Obst. & Gynec. 91:65-75 (Jan) 65.**

This is a report and discussion of three instances of rupture of the amnion in human pregnancies and the resulting damage to the fetus in the form of constricting lesions or amputations of the extremities, and these were associated in two instances with clubbing of the feet. Chaussier of Paris in 1812, and Watkinson of England in 1824, each discovered a newborn infant with an amputated extremity and the amputated part was expelled and recovered from the membranes. In 1832, Montgomery of Dublin collected a few cases and considered the situation to be due

to strands of organized lymph in the amniotic fluid. The author concludes that when the amnion ruptures it detaches fibrous strings from the chorion which then float free in the sac. He also concludes that when the amnion ruptures the amniotic fluid is, temporarily at least, absorbed by the amnion denuded chorion. This puts pressure in some cases on the fetus to induce clubbing of the feet or other pressure effects. The chorion later toughens, becoming thick and smooth and is then able to retain the fluid which is subsequently formed. If the rupture takes place very early in pregnancy the fetus is too small to be so effected but it may sweep up strings which encircle fingers or toes.

**Harkess, James W., M.B.Ch.B., Medical College of Georgia, Augusta, Georgia, "Parosteal Osteosarcoma," Am. Surg. 30:730-7v6 (Nov) 64.**

Parosteal osteosarcoma is a relatively benign form of osteosarcoma which arises from the soft tissues contiguous with bone. In contradistinction to central osteosarcoma, which is commonest in childhood, the maximum incidence of this tumor is in the fourth and fifth decades.

Clinically, parosteal osteosarcoma presents as a large, lobulated, non-tender mass which is fixed to the underlying bone. Eventually the tumor will invade the adjacent bone and soft tissue and after an interval, sometimes as long as 20 or 30 years, pulmonary metastases result. The tumor characteristically occurs in relation to the metaphysics of a long bone and more than 50% involve the distal end of the femur.

Histologically, the neoplastic tissue is deceptively benign and consists of trabeculae of bone, islands of cartilage and atypical spindle or polyhedral cells. In most cases the pathological diagnosis made is myositis ossificans or osteocartilaginous exostosis.

The author reports three cases of this entity to illustrate the differing clinical manifestations of the disease. The first is a classical parosteal osteosarcoma involving the shaft of the tibia. The second, a multicentric tumor involving a multiplicity of sites, did not metastasize to the lungs until 27 years after the first tumor was excised. In the third case, the proximal phalanx of an index finger was involved.

These tumors should be treated by radical local excision where feasible or by amputation. Local excision is commonly followed by a recurrence of the tumor and amputation is then mandatory.

**Mingledorff, Walter E., M.D.; J. Robert Rinker, M.D.; and Glen Owen, Medical College of Georgia, Augusta, Georgia, "Experimental Study of the Blood Supply of the Distal Ureter with Ref-**

**erence to Cutaneous Ureterostomy," J. Urol. 92:424-428 (Nov) 64**

The normal distal ureter rather consistently becomes necrotic and sloughs postoperatively following cutaneous ureterostomy; conversely, the thick-walled dilated ureter usually survives under the same circumstances and with apparently similar blood supply. It was postulated that inadequate venous return and altered arterial supply may be cause for the slough, interference in development of collateral circulation by clot formation or other coagulation factors at the site of severance of the ureter may also contribute. To duplicate these conditions in dogs, the left ureter was cut and allowed to bleed freely in situ. The right ureter was ligated at the same distal level.

These unskeletonized ureters were allowed to lie in their respective beds, receiving normal regional blood supply from above, following vascular insult distally at the level where usually divided in cutaneous ureterostomy. Changes in the vascular plexus were observed with the dissecting microscope after infusion with silicone rubber media via the renal artery, at intervals of from one hour to seven days. Observations indicated that chances of survival of the distal ureter when severed from its regional blood supply and transplanted to skin (as in cutaneous ureterostomy) should be markedly increased, provided the ureter is not skeletonized and remains in situ for at least seven days following preliminary interruption of its distal blood supply.

**Rinker, J. Robert, M.D., and David C. Williams, Jr., M.D., Medical College of Georgia, Augusta, Georgia, "Urinoma: Differential Diagnosis of Pseudocyst in Abdomen," Am. Surg. 30:717-720(Nov)64.**

A pseudocyst is formed by leakage of sterile urine or pancreatic juice through a rent into the surrounding tissue with no adequate route of escape. It usually follows a small overlooked injury to the drainage system such as a gunshot wound. Cysts are rare after surgery because drainage of the area is a standard practice where leakage might occur. Pseudocysts of the pancreas can cause extrinsic pressure on the urinary tract and produce an abnormal pyelogram, making a problem in differential diagnosis. If pyelograms fail to establish the condition, it may be demonstrated on x-ray by needle aspiration of the cyst and injection of Hypaque, provided it is accessible and located where the procedure is safe. Analysis of the aspirated fluid may be helpful. Values may be variable, since with stasis the enzymatic activity may be spent and constituents of the urine tend to approach the levels of blood serum. A definite diagnosis should be made before surgical intervention.





# THE ASSOCIATION

## DEATHS

**DOUGLAS HEAD, SR.**, 67, of Zebulon, died in Upson County Hospital February 3, 1965. Survivors include his wife, Mrs. Adele Smith Head; a daughter, Mrs. W. J. Richardson, Savannah; a son, Dr. Doug Head Jr., Thomaston; a sister, Miss Lutie Head of Zebulon; a brother, Mr. Horace Head, Anniston, Ala. and five grandchildren.

**MERRILL I. LINEBACK**, formerly of East Point, died December 21, 1964, in Salt Lake City, Utah. Dr. Lineback was moving from Atlanta to Salt Lake City and upon his arrival was immediately hospitalized. He died of cardiac failure.

Dr. Lineback is survived by his wife and seven children.

**J. O. SIMMONS**, Camden physician, died in Woodbine Hospital January 6, 1965. He had been in declining health.

Coming to Woodbine in the late 1930's, Dr. Simmons was first associated with the late Dr. A. K. Swift. Later he opened his own practice at the Woodbine Hospital. He was a native of Brunswick and his father was also a physician. He received his B.A. and M.D. degrees from Emory University and interned at Emory University Hospital in Atlanta. Following a tour of duty with the Air Force he came to Woodbine.

He served as a Secretary of the Camden-Charlton Medical Society, at one time was a member of the staff of the Glynn-Brunswick Memorial Hospital, a member of the Medical Association of Georgia and the American Medical Association. A member of the Methodist Church he served on the Official Board in several capacities. He was also a member of the Woodbine Lions Club, a Mason and was a physician for the Seaboard Railroad. He was active in P.T.A. work and served as Vice President one year and Program Chairman for which he received a plaque for his outstanding work.

Surviving is his wife, Mrs. J. O. Simmons, Woodbine; three daughters, Judy Ann Simmons, Jacqueline Simmons and Jimmie Lee Simmons, all of Woodbine; a brother, Jack Simmons of Brunswick; a sister, Mrs. Don Garrett of Atlanta.

## SOCIETIES

**Robert Mainor, M.D.** of Smyrna has recently been installed as the new President of the **COBB COUNTY MEDICAL SOCIETY**. Other officers are **E. A. Vaughn, M.D.**, Marietta, Vice President, and **Warren Matthews, M.D.**, Marietta, Secretary. **George Hagood, Marietta, M.D.**, the oldest living member of the society, will continue to serve as Parliamentarian. **Robert B. Greenblatt**, Professor of Endocrinology, Medical College of Georgia, Augusta, was the guest speaker.

**CRAWFORD W. LONG MEDICAL SOCIETY**, Athens, has elected the following officers for 1965—**George Ervin, M.D.**, President; **Ramon Thompson, M.D.**, Vice President; **William Crosby, M.D.**, Secretary-Treasurer; **Royce Banister, M.D.**, AMA Delegate, and **Harvey Cabiness, M.D.**, Alternate; and **Dillard Nix, M.D.**, Chairman of GaMPAC.

**Gerald Hall Holman, M.D.**, Pediatric Endocrinologist, Professor of Pediatrics and Chairman of the Department of Pediatrics at the Medical College of Georgia, Augusta, was the guest speaker at the January meeting of the **GEORGIA MEDICAL SOCIETY**. Dr. Holman's subject was "Adrenogenital Syndrome," which he illustrated with slides.

**WHITFIELD COUNTY MEDICAL SOCIETY** in co-sponsorship with Friendship House of Dalton, has begun an Adult Education Program. Classes will be conducted twice each week throughout the year with a two-week break for summer vacation. The Program is modeled after the Chattanooga Area Literacy Movement and is this year celebrating its fifth anniversary. Classes offer instruction in reading, writing, spelling, English and basic arithmetic.

**BIBB COUNTY MEDICAL SOCIETY** presented a program, "The Role of Religion in the Practice of Medicine," at its first 1965 meeting. A panel of Macon clergymen participated. **Jasper T. Hogan, M.D.** served as Chairman.

## PERSONALS

### First District

**J. MOULTRIE LEE**, Savannah, has recently been elected Chief of Surgery at St. Joseph's Hospital. Other department chiefs include **J. J. DOOLAN, OB-GYN**, **WILLIAM B. CRAWFORD, JR.**, General Practice; and **FENWICH NICHOLS**, Medicine. Three elected to the Executive Committee were **F. D. MANER**, Internal Medicine; **E. J. WHALAN**, Surgery; and **DEARING A. NASH**, General Practice.

**WILLIAM W. OSBORNE** and **JOHN L. ELLIOTT** were re-elected President and Vice President respectively of the Physicians Service Association of Savannah, Inc., January 22, 1965. Directors re-elected to the board were **L. M. FREEDMAN**, **R. B. GOTTSCHALK**, **J. J. HOLLOMAN**, and **W. L. OSTEEN**.

**JACOB RUBIN**, Savannah, has recently been elected to the Board of Directors of Home Federal Savings and Loan Association of Savannah.

## Third District

Americus physician, E. W. WALDERMAYER, has been named medical officer of the Atlanta regional office of the Civil Service Commission. In the new post Dr. Waldermeyer will have supervision of medical activities in Tennessee, North and South Carolina, Florida, Alabama, Mississippi and Georgia. A native of Kentucky, Dr. Waldermayer has practiced medicine in Americus since 1963.

EARL A. MAYO, Richland, was appointed December 31, 1964, as a member of the State Board of Medical Examiners for a term beginning December 31, 1964, and ending September 1, 1968. He is succeeding FRED J. COLEMAN, Dublin, whose term of office has expired.

## Fifth District

JOHN T. MAULDIN, Atlanta, Secretary of the Medical Association of Georgia, was the guest speaker at the

Toccoa Lions Club Meeting January 26, 1965. Dr. Mauldin discussed the state Kerr-Mills Law and the new Eldercare Plan proposed by the AMA.

HIRAM M. STURM, Atlanta, has recently been elected President of the Atlanta Dermatological Association. ROBERT M. FINE, Decatur, was elected secretary.

## Eighth District

JAMES S. PETERS, JR., Nashville, has recently given up his medical practice in Nashville after 22 years to become a member of the staff of Grady Memorial Hospital in Atlanta, where he will serve as a fellow in radiology.

## Ninth District

ROBERT E. THOMPSON, Toccoa, has recently been named Outstanding Young Man of the Year in recent ceremonies in that city.

JAMES B. KNOWLES has recently become associated with the Ellijay Clinic, Ellijay, Georgia.

# CONTROLS MUST BE INFORMED— LIKE PATIENTS

It is worth noting that the law. . . (now) requires the investigator of new drugs to inform "any persons used as controls" that "drugs are being used for investigational purposes." The term "drugs" is confusing because it could refer to the new drug itself or to placebos or standard drugs given to the controls. Disclosure of full information to the controls may be highly detrimental to the drug study. Such disclosure introduces a highly undesirable psychologic element, inconsistent

with the statutory requirement for adequate and well controlled studies for proving the effectiveness of a new drug. The conclusion is inescapable. The federal regulations and, if need be, the law, should be modified, so as not to interfere with medical practice and the orderly investigation of new drugs.—Francis Boyer, Chairman of the Board, Smith Kline and French Laboratories, in *New England Journal of Medicine*, 270: 15, (April 9,) 1964.

# NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Name</i>	<i>Address</i>
Holt, Edward Active—Cook-Berrien	309 S. Burwell Ave. Adel, Georgia	Nino, Homero F. Active—Crawford W. Long	St. Marys Hospital Athens, Georgia
Jordan, James A. Active—Crawford W. Long	C & S Bank Building Athens, Georgia	Peirce, E. Converse, II Active—Fulton	454 Woodruff Memorial Bldg. Atlanta, Georgia 30322
McGinty, W. Ray, Jr. Active—Colquitt	408 Commercial Bldg. Moultrie, Georgia	Reynolds, Wilton B., Jr. Active—Southwest Georgia	P. O. Box 327 Edison, Georgia
Mercer, Franklin E. Active—Southwest Georgia	Calhoun Clinic Blakely, Georgia	Rowe, William E. Active—Walker-Catoosa-Dade	509 Doctors Building Chattanooga, Tenn. 37402



**JOURNAL**  
OF THE MEDICAL  
ASSOCIATION

APRIL / 1965  
*Georgia*

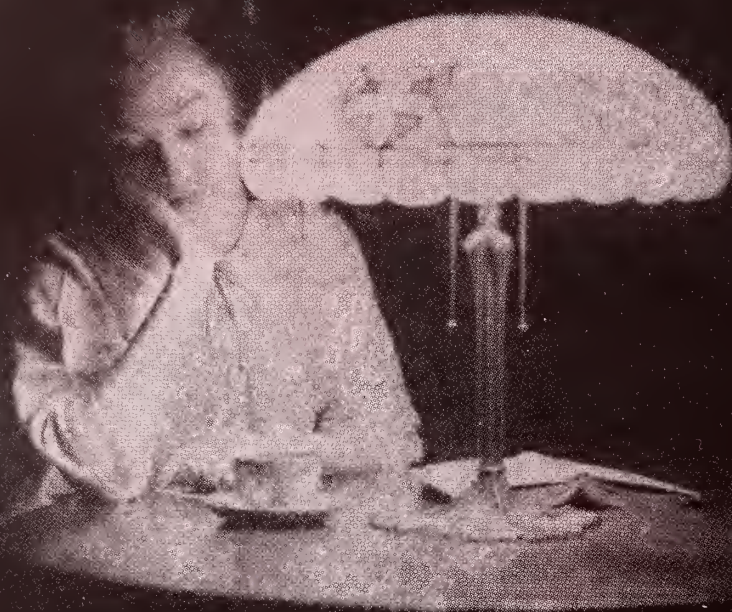
U.C. MEDICAL CENTER LIBRARY

MAY 5 1965

San Francisco 94122



**OLD MEDICAL COLLEGE BUILDING  
AUGUSTA**



## epilepsy can undermine self-reliance

"A therapeutic 'bull's-eye' may be scored with DILANTIN [diphenylhydantoin] even for a person with long-standing convulsions previously unrelieved by phenobarbital."\* Such efficacy can make a substantial contribution to your epileptic patient's rehabilitation...improve his prospects for employment...foster greater self-reliance.

**Indications:** Grand mal epilepsy and certain other convulsive states. **Precautions:** Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. **Side Effects:** Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Upon discontinuation of therapy eruptions usually subside. Rarely, dermatitis goes

on to exfoliation with hepatitis, and further dosage is contraindicated. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Hematologic disorders including megaloblastic anemia, leukopenia, granulocytopenia, pancytopenia, and aplastic anemia have been reported. Nystagmus may develop. DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm.

\*Lennox, W. G.: Epilepsy and Related Disorders, Boston, Little, Brown and Company, 1960, vol. 2, p. 865.

**PARKE-DAVIS**

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232

# Dilantin®

(diphenylhydantoin)

PARKE-DAVIS

## helps to restore confidence



JOURNAL  
OF THE MEDICAL  
ASSOCIATION

Georgía

Contents

EDITOR

Edgar Woody, Jr., M.D.

MANAGING EDITOR

Merrilie M. Davis

STAFF

Thelma V. Franklin, *Business*

CONTRIBUTING EDITORS

Herbert S. Alden, M.D.; Preston D. Ellington, M.D.; Thomas Findley, M.D.; J. Willis Hurst, M.D.; Charles S. Jones, M.D.; Arthur M. Knight, Jr., M.D.; Arthur J. Merrill, M.D.; Lester Rumble, Jr., M.D.; Peter L. Scardino, M.D.; Patrick C. Shea, Jr., M.D.; Robert H. Vaughan, M.D.

PUBLICATIONS COMMITTEE

J. G. McDaniel, M.D.; George H. Alexander, M.D.; George R. Dillinger, M.D.; John Kirk Train, M.D.; A. W. Simpson, M.D.; John T. Mauldin, M.D.; John S. Atwater, M.D.; C. R. Andrews, M.D.

THE ASSOCIATION

J. G. McDaniel, M.D., *Pres.*; George H. Alexander, M.D., *Pres.-Elect*; George R. Dillinger, M.D., *Past Pres.*; A. W. Simpson, M.D., *Chm. of Council*; John T. Mauldin, M.D., *Sec.*; John S. Atwater, M.D., *Treas.*; J. Frank Walker, M.D., *Speaker*; Mr. Milton D. Krueger, *Exec. Sec.*; Mr. James M. Moffett, *Asst. Exec. Sec.*; Mrs. Catherine Wooten, *Asst. Exec. Sec.*

THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and copyrighted, 1965, by the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309. Published monthly under the direction of the Council of the Association. Subscription rate: \$7 per year; \$1 per single copy. Second-class postage paid at Atlanta, Georgia.

Scientific Articles

BACTERURIA IN PREGNANCY	
E. J. Quilligan, M.D. and R. O. Oseasohn, M.D. . . . .	113
THE ETIOLOGICAL ROLE OF CHRONIC BRONCHITIS IN OBSTRUCTIVE PULMONARY EMPHYSEMA	
Elizabeth Singletary, M.D.	
B. Shannon Gallaher, M.D. . . . .	116
SEROUS OTITIS MEDIA	
E. F. Staats, M.D. . . . .	121

Editorials

THE T3 TEST . . . . .	126
A WELCOME TO OLD FRIENDS . . . . .	127
MEDICAL EDUCATION AND THE PRACTICING PHYSICIAN . . . . .	127
RESPONSE TO JOURNAL QUESTIONNAIRE . . . . .	128
STATE LEGISLATIVE WRAP-UP FOR 1965 . . . . .	128

Features

President's Letter . . . . .	131
Cancer Page . . . . .	132
Heart Page . . . . .	133
Legal Page . . . . .	134
Abstracts . . . . .	136

The Association

Deaths . . . . .	139
Societies . . . . .	139
Personals . . . . .	140
Advertising Index . . . . .	42A
Calendar . . . . .	115

Cover

In the early 1800's, herb doctors and other self-professed healers greatly outnumbered physicians. All totaled, by 1820, there were less than a dozen qualified physicians in what is now referred to as the Central Savannah River Area. In 1822 this group formed the Augusta Medical Society. In reality the conception of the Medical College occurred with the formation of the society.

In 1828, Milton Anthony, L. D. Ford, and others obtained a charter for the Medical Academy of Georgia and the next year with three faculty members, modestly began its operation with a few students. In 1830 the Academy was rechartered as the Medical Institute of Georgia and in 1833 the name was changed to the Medical College of Georgia. The Old Medical College Building on Telfair Street was erected in 1835 as the Medical College of Georgia.

IN FUNCTIONAL  
G.I. DISTURBANCE



## **“My cooking agrees with everyone but me”**

She complains about her upset stomach and blames her cooking...you diagnose functional G.I. disturbance and associated stress...as manifested by indigestion, heartburn, bloating, or constipation. Prescribe

## **DECHOLIN-BB®**

(Hydrocholeretic•Antispasmodic•Sedative, AMES)

Each Tablet Contains:

BUTABARBITAL SODIUM ..... 15 mg (¼ gr)  
(Warning: May be habit forming) to ease nervous tension

DEHYDROCHOLIC ACID ..... 250 mg (3¾ gr)  
to produce a large volume of watery bile, hydrate  
the bowel contents and gently stimulate intestinal  
motility

BELLADONNA EXTRACT ..... 10 mg (¼ gr)  
to reduce smooth-muscle hypertonus

Average Adult Dose: 1, or if needed, 2 tablets three times daily. Precautions: Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction. Caution drivers against possible drowsiness. Side Effects: Dehydrocholic acid may cause transitory diarrhea; belladonna—blurred vision, dry mouth. Contraindications: Biliary tract obstruction, acute hepatitis, glaucoma, and prostatic hyperplasia.

Available through your regular supplier:  
DECHOLIN-BB, bottles of 100 tablets.



Ames Company, Inc., Elkhart, Indiana **AMES**



## BACTERURIA IN PREGNANCY

E. J. Quilligan, M.D. and R. O. Oseasohn, M.D., *Cleveland, Ohio*

- In the authors' experience, the majority of asymptomatic bacillurias will resolve spontaneously.

THE INVESTIGATION of pyelonephritis goes well back into the last century; however, the current resurgence of investigative activity started about 1954-1955. In 1955 Beeson<sup>1</sup> wrote a review article in the *Yale Journal of Biology and Medicine* entitled "Factors in the Pathogenesis of Pyelonephritis." From the evidence then available he reached the following conclusion: (a) Infection of the kidney and/or bladder can destroy renal tissue and yet remain asymptomatic; (b) There are certain conditions in which renal infection is more common, i.e. obstruction to urine flow, interference with bladder innervation, and diabetes mellitus; (c) The urethra is frequently infected, therefore, instrumentation transurethritically could lead to increased bladder infection; and (d) Reflex infection from bladder to kidney via the ureter was possible and probable, therefore increased bladder infection would lead to increased renal infection.

### Routine Urine Cultures

The only method to investigate asymptomatic infection would be routine urine cultures in all patients. This presented a problem in the female since it had always been felt that any urine specimen not obtained by catheterization would be worthless for the interpretation of bacteruria. However, Kass<sup>2</sup> demonstrated that if the perineum and vestibule were properly cleansed and a mid stream specimen obtained, interpretation of true bacilluria and not contamination could be made. He found that if there were greater than  $10^5$  colonies of bacteria per milliliter of urine in a single clean voided specimen, an 88% correlation could be obtained with a catheterized specimen. If there were greater than  $10^5$  colonies of bacteria in two consecutive specimens then

there was a 95% correlation with a catheter obtained specimen. Kass further defined the incidence of asymptomatic bacilluria in the population when in a large random survey he found 6% of females (pregnant or nonpregnant), 4% of males, 18% of diabetic females, 5% of diabetic males, 23% of women with cystoceles, 98% of patients with an indwelling catheter for 48 hours, and 2% of those with previously sterile urines after a single catheterization would have bacilluria.

### Many Studies

Since the pregnant female has frequently been subjected to catheterization particularly at delivery, many studies of her incidence of bacilluria have been done. One of the most striking and potentially significant findings has been the reports of an increased incidence of prematurity associated with bacilluria. Both Kass<sup>3</sup> and Henderson<sup>4</sup> have found the prematurity rate to double when associated bacilluria was present during the pregnancy. However Kaitz<sup>5</sup> and Turck<sup>6</sup> have been unable to conclude this from their series.

A second finding of Kass<sup>7</sup> in the pregnant female is also worthy of note. He found that treating asymptomatic bacilluria markedly decreased the incidence of pyelonephritis of pregnancy. A study by Davis<sup>8</sup> and coworkers similarly found that routine antibiotics decreased the incidence of post delivery catheterization cystitis. Kunin and Halmagyi<sup>9</sup> have serotyped the organisms found in bacilluria. Most of the bacteria are sulfa sensitive and once an organism is irradiated that same type doesn't tend to recur.

This study involved 403 women divided into three series. In the initial series 193 women who gave no clinical history of cystitis or pyelonephritis had a catheterized urine obtained at delivery and again on the third postpartum day. The second series had 163 women who were more closely questioned about previous urinary tract infection by one

From the Departments of Obstetrics and Gynecology, and Preventive Medicine, Western Reserve University School of Medicine.

Presented at the 110th Annual Session of the Medical Association of Georgia, May 5, 1964, Macon, Georgia.

of the authors (R.O.). All were catheterized at delivery then all were catheterized on the third postpartum day. The third series consisted of 47 patients followed for up to one year after bacilluria. Ten of these patients were treated and 37 were not treated.

0.1 cc aliquots and a 1:100 dilution of urine were placed on nutrient agar plates and in broth. Colony counts of bacteria were done on the basis of number of colonies per cc of urine and greater than 100,000 colonies per ml of urine were considered significant.

### Results

In study number one 9.8% of the patients had bacilluria on the initial culture at the time of delivery and 19.5% had a positive urine culture at 72 hours postpartum. In study number two 4.9% had bacilluria at delivery and 29.1% had positive cultures on the third postpartum day.

Age, race, and parity were examined as possible host factors influencing bacilluria. The age groups were divided into ten year increments according to the year of maternal birth (see Table I). It is

TABLE I  
Maternal Age and Bacilluria

Year of Birth	Study No. 1		Study No. 2	
	Pos. Culture	Neg. Culture	Pos. Culture	Neg. Culture
1915-24	6.8%	8.4%	0	4.8%
1925-34	37.9%	35.2%	30.8%	42.1%
1935-44	55.1%	55.4%	66.5%	51.8%
1945-	0.0%	0.8%	2.3%	0.9%

apparent that the percentage of the study populations having either a positive or negative culture is similar for all age groups. This was true in both series. Similar findings were present when race and parity were examined (see Tables II and III).

Prematurity as a factor associated with bacilluria in this series was likewise examined by comparing the fetal weight groups in patients having a positive or negative urine culture (see Table IV). The total percentage of infants delivered weighing under 2500 grams was the same regardless of the presence or absence of urinary tract bacteria.

A possible iatrogenic factor was next examined. Since the definition of onset of labor is difficult, we chose to examine the patient's hospital stay in hours. This may reflect hospital environment, number of physician examinations, and even indirectly the length of labor. Here we did find that when the patient was in the hospital over 13 hours the incidence of bacilluria rose significantly (see Table V).

TABLE II  
Race and Bacteruria

	Positive Culture	Negative Culture
White	33%	66%
Non White	23%	80%

The last study involved 47 patients who were followed postpartum for one year in most instances. Thirty-seven of these patients were not treated and ten were treated. The patients were treated only when symptomatic cystitis or pyelonephritis was apparent. Nineteen of the patients were negative for bacilluria in the first two weeks postpartum when daily urine cultures were done. Of this group one was positive at six weeks, two were positive at 12 weeks, and one was positive at one year. There were 11 patients having one or two positive urine cultures during the first two weeks postpartum. One was positive at six weeks, and one positive at 12 weeks. None were positive at one year. Seven pa-

TABLE III  
Parity and Bacteruria

Parity	Study No. 1		Study No. 2	
	Pos. Culture	Neg. Culture	Pos. Culture	Neg. Culture
0	20.6%	29.4%	42.8%	26.4%
1	31.0%	22.6%	16.6%	16.6%
2	13.7%	16.8%	19.0%	18.6%
3+	34.4%	31.0%	21.4%	38.2%

tients had three or more positive cultures in the first two weeks. Three of these seven were positive at six weeks, two of seven at 12 weeks, and one of seven at one year. In the ten treated patients, one was positive at six weeks, two were positive at 12 weeks and none positive at one year (see Table VI).

These studies would indicate to us that race, age, and parity are not important host factors in the acquisition of bacilluria. Catheterization and length of hospital stay in labor do seem to play a role. Does this mean that bladder catheterization should be avoided at all costs? Not necessarily but it should be used judiciously as should any procedure. The risks must be weighed, bacilluria versus bladder damage. When the fetal presenting part is on the perineum, the bladder is out of the way of any injury, thus most patients delivering do not need to be catheterized. Should high mid forceps or intra-urine manipulation be necessary, the potential for

TABLE IV  
Birth Weight of Infant and Maternal Bacilluria

Birth Weight	Study No. 1		Study No. 2	
	Pos. Culture	Neg. Culture	Pos. Culture	Neg. Culture
-2000	0.0%	5.8%	2.3%	3.7%
2000-2499	6.8%	9.2%	11.8%	6.8%
2500-2999	31.0%	25.2%	30.9%	34.2%
3000-	62.0%	59.6%	52.2%	52.9%



TABLE V  
Relationship of Time in Hospital and Bacteruria

Time in Hospital	Positive Culture	Negative Culture
➤ 13 HOURS	20.6%	6.7%
← 13 HOURS	79.4%	93.3%

injury of a full bladder is present and the bladder should be emptied.

We could not find the high prematurity rate found in some studies. The difference could lie in the relatively small size of our study or in the severity of the infection. Acute pyelonephritis is associated with a higher prematurity rate.

The necessity of treating all cases of asymptomatic bacilluria is open to question. Certainly these studies would indicate that host resistance plays a very important role and the majority of asymptomatic bacillurias will spontaneously resolve.

### Summary

- (1) Factors in the acquisition of bacilluria in the pregnant woman have been examined and only catheterization and hospital stay appear to be significant.
- (2) Prematurity was not increased in those patients having bacilluria.
- (3) The majority of cases of asymptomatic bacilluria will resolve spontaneously.

TABLE VI  
Fate of Postpartum Bacteruria in 47 Patients

First Two Postpartum Weeks		Number Positive at Follow-up Intervals		
No. Pts.	Pos. tests	6 wks.	12 wks.	1 year
Untreated:				
19	0	1/18*	2/19	1/17*†
11	1-2	1/11	1/11	0/9
7	3+	3/7	2/7	1/7
Treated:				
10	—	1/9*	2/9*	0/8*

\*Difference due to missing test(s)

†One case excluded due to recent delivery

### BIBLIOGRAPHY

1. Beeson, P. B.: Factors in the Pathogenesis of Pyelonephritis. *Yale J. Biol. & Med.* 28:81, 1955.
2. Kass, E. H.: Chemotherapeutic and Antibiotic Drugs in the Management of Infections of the Urinary Tract. *Am. J. Med.* 18:764, 1955.
3. Kass, E. H.: Pyelonephritis and Bacteruria. *Ann. of Int. Med.* 56:46, 1962.
4. Henderson, M.; Tayback, M., and Entwisle, G.: Prevalence of Asymptomatic Bacteruria and its Association with Prematurity in Negro and White Women. *Clin. Research* 9:202, 1961.
5. Kaitz, A. L., and Hodder, E. W.: Bacteruria and Pyelonephritis of Pregnancy. *New Eng. J. Med.* 265:667, 1961.
6. Turek, M., Goffe, B., and Petersdorf, R.G.: Bacteruria of Pregnancy. *New Eng. J. Med.* 266:857, 1962.
7. Kass, E. H.: Bacteruria and Pyelonephritis of Pregnancy. *AMA Arch Int. Med.* 105:194, 1960.
8. Davis, J. H.; Rosenblum, J. M.; Quilligan, E. J., and Persky, L.: Evaluation of Post-catheterization Prophylactic Chemotherapy. *J. Urol.* 86:613, 1959.
9. Kunin, C. M., and Halmagyi, N. E.: Urinary Tract Infection in School Children. *New Eng. J. Med.* 261:1297, 1962.

## 1965 CALENDAR OF MEETINGS

### State

- April 23-24—Southeastern Section of the Association for Research in Ophthalmology, Emory University, Atlanta.
- April 23-24—Postgraduate Courses in "Radioisotope Scanning in Clinical Practice," sponsored by the Department of Radiology, Division of Nuclear Medicine, of Emory University School of Medicine, Grady Memorial Hospital, Atlanta.
- April 26-28—A Symposium, "Three Days of Liver Disease," presented by the Department of Medicine, Emory University School of Medicine, Grady Memorial Hospital Auditorium, Atlanta.
- May 1-2—Lung Disease Seminar, Educational Building of the Medical College of Georgia, Augusta.
- May 2-4—111th Annual Session of the Medical Association of Georgia, Augusta.
- May 17-18—Postgraduate Seminar, "Obstetrical Factors in Child Development," presented by the Department of Gynecology and Obstetrics, Emory University School of Medicine, Grady Memorial Hospital, Atlanta.

### Regional

- April 22-24—Medical Association of the State of Alabama, Birmingham, Ala.
- April 26-29—American Academy of Pediatrics, Americana Hotel, Bal Harbour, Fla.
- April 28-May 1—West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, W. Va.

- May 1-5—Medical Society of the State of North Carolina, Queen Charlotte Hotel, Charlotte, N. C.
- May 2-5—American Association of Plastic Surgeons, Boca Raton Hotel, Boca Raton, Fla.
- May 9-13—American Urological Association, Roosevelt Hotel, New Orleans.
- May 10-13—Mississippi State Medical Association, Biloxi, Miss.
- May 14-15—Louisiana-Mississippi Ophthalmological and Otolaryngological Society, Edgewater Gulf Hotel, Biloxi, Miss.
- May 27-29—American Ophthalmological Society, Homestead Hotel, Hot Springs, Va.
- June 16-19—Society of Nuclear Medicine, Americana Hotel, Bal Harbour, Fla.
- June 28-July 1—American Orthopaedic Association, Hot Springs, Va.

### National

- May 24-28—A Five Day Refresher Course in Pediatrics sponsored by the Children's Hospital of Philadelphia and the Department of Pediatrics, School of Medicine, University of Pennsylvania, Philadelphia, Pa.
- June 16—American Cancer Society, 1965 Scientific Session, Drake Hotel, Philadelphia, Pa.
- June 20-24, 1965—American Medical Association, Americana Hotel, New York City.

# THE ETIOLOGICAL ROLE OF CHRONIC BRONCHITIS IN OBSTRUCTIVE PULMONARY EMPHYSEMA

Elizabeth Singletary\*

B. Shannon Gallaher, M.D., *Augusta*

- Twenty illustrative case histories are summarized.
- A brief review of the current literature is presented.

THE TERM chronic bronchitis was introduced to medical literature by Badham in 1808 and was used to imply inflammation of the bronchi of a non-specific etiology. Laennec (1819) used the term emphysema to indicate a morbid anatomical state of hypertrophic lungs which was the result of partial bronchial obstruction, a view that remains widely held. The Greek meaning of the word "emphysema" is to blow or inflate.

## Definition

In the current literature, unqualified use of the word emphysema can denote anything from a kyphotic chest deformity of old age to the hyperinflated chest of children with acute bronchial asthma. Pulmonary emphysema is divided into the obstructive and non-obstructive types. Included in the obstructive type is centrilobular, panacinar, focal, fibrotic, and bullous emphysema. The non-obstructive types are compensatory, senile, and that type associated with thoracic cage deformity. Pulmonary emphysema, in general, denotes a pathological increase in size of the air passages distal to the terminal bronchioles, due to dilatation and/or destruction of the walls. Some authors include under the term emphysema dilatation involving all respiratory passages which bear alveoli.

One type of obstructive pulmonary emphysema, centrilobular emphysema, selectively affects the respiratory bronchiole, resulting in dilatation of air spaces in the proximal portion of the acini producing a state of bronchiectasis; the lesion may be

widespread or local. Panacinar emphysema indicates uniform dilatation of all air passages distal to the terminal bronchiole, usually in unselective distribution. Focal emphysema is associated with coal-workers' pneumoconiosis and the fibrotic type with Hamman-Rich syndrome.

Non-obstructive compensatory emphysema follows lobectomy, pneumonectomy, etc. Senile emphysema represents one of the atrophic changes seen with age and represents the loss of elasticity of pulmonary tissue, leading to dilatation of air spaces. No definite symptoms are found in these individuals, who are otherwise healthy. Thoracic cage abnormalities, such as kyphotic distortion of the dorsal spine, are also seen as a cause of non-obstructive pulmonary emphysema.

Chronic bronchitis is a clinical disorder characterized by excessive mucus secretion in the bronchial tree. In this condition there is a chronic or recurrent productive cough occurring on most days for at least three months in a year for at least two successive years.

## Clinical Case History Abstracts

Twenty patients with chronic obstructive pulmonary emphysema diagnosed initially by physical findings and confirmed by pulmonary function studies are summarized. Patients were selected at random.

It is felt by most authors that roentgenography is of little help in the diagnosis of chronic obstructive pulmonary emphysema until the disease is advanced. All of the patients reported had chest films (P.A. and Lateral). Eleven had evidence of pulmonary emphysema (mild to severe). In other words, eleven patients had a large thoracic cage with low diaphragms, apparent horizontal position of ribs with

\*Intern, University Hospital, Augusta, Georgia.

Presented, in part, at the 110th Annual Session of the Medical Association of Georgia, May 4, 1964, Macon, Georgia.



TABLE #1 - CLINICAL DATA ON 20 CASES OF EMPHYSEMA

Pt. No.	Age (yrs.)	Sex	Ht. (in.)	Wt. (lb.)	Total Duration of Shortness of Breath (yrs.)	Bronchitis or Asthma Preceding Dyspnea	X-Ray Evidence of Emph	History of Cardiac Failure	Rt. Heart Enlargement (EKG/X-Ray Evidence)	Cigrtte. Smoking (pkg/day)	Occupation
1	63	♀	61	116	0	None	Yes	Yes	Yes	1/4	Housewife
2	69	♂	68	130	10	None	Yes	No	No	1	Farmer
3	55	♂	68	188	Several yrs.	Yes	No*	No	No	2½	City Locks Foreman
4	55	♂	70	143	Several yrs.	Yes	Yes	No	No	1	Car Salesman
5	61	♂	65	151	Several yrs.	Yes	No*	No	No	2	Car Salesman
6	58	♂	66	140	1	Yes	Yes	No	No	2	Carpenter (ret.)
7	43	♂	70	130	4	Yes	Yes	No	Yes	2	Plumber
8	58	♂	69	154	8	Yes	Yes	No	Yes	2	Crain Operator
9	54	♂	66	120	3	+Yes	Yes	No	No	½	Construction
10	69	♂	68	160	10	Yes	Yes	No	No	1½	Tel. Lineman (ret.)
11	65	♂	71	177	4	+Yes	Yes	No	Yes	2	Railroad Yard Master
12	45	♂	68	145	Several yrs.	Yes	Yes	No	Yes	3	Accountant
13	41	♀	64	134	4	Yes	Yes	No	No	2	Newspaper (sec.)
14	64	♂	66	144	½	Yes	No*	Yes	No	1	Auditor
15	50	♂	69	183	1½	Yes	No*	No	No	2	Paint Contractor
16	49	♂	68	215	5	+Yes	No*	No	No	Chew tob.	Riveter
17	52	♂	66	197	20	+Yes	No*	No	No	½	Farmer / Construct.
18	47	♂	66	109	4	Yes	No**	No	No	1	Carpenter
19	56	♀	67	164	12	+Yes	No*	Yes	Yes	1	Textile Worker (ret.)
20	52	♂	66	134	3	Yes	Yes	No	No	1/4	Unemployed

\* Evidence of Chronic Bronchitis (mild to severe)

\*\* Evidence of Bilat. Pulmonary Fibrotic Change

+ "Asthma"

wide intercostal spaces, vertical heart which appeared small, hilar vascular shadows which were frequently prominent, and small peripheral vessels which also appeared to be decreased in number. Of the remaining nine, all were interpreted as having mild to moderate chronic bronchitis, except one who had bilateral pulmonary fibrotic changes. (Table I).

### Interesting Ratio

It is interesting to note that only three of the patients were females, a ratio of 6.7 males to 1 female. The ages ranged from 41 yrs. to 69 yrs. with an average age of 55.3 yrs. Five gave a history of "asthma" and eleven mentioned having had whooping cough as children. Nineteen stated that they had had "shortness of breath" from six months to twenty years prior to their initial visit, the average duration being 5.8 years. One patient denied dyspnea in the past history, but he had a history of cardiac decompensation, pulmonary emphysema by x-ray and evidence of chronic cor-pulmonale on EKG (Table I).

Nineteen of the patients gave a history of cigarette smoking for many years. They averaged, or admitted to, 1.5 packs/day. The only patient who did not give a positive cigarette smoking history did admit to chewing tobacco (Table I).

### Occupations

The occupations of the patients revealed no correlation between those who worked mainly out-of-

doors and those who spent the majority of their time in-doors. Included in the group were one white female housewife, several construction workers, auditors, accountants, farmers, carpenters, and one unemployed Negro male who gave no job history (Table I).

Pulmonary function studies are shown in Table II. Total vital capacities of all patients ranged from 95% to 36% of the predicted normal value. The maximum expiratory flow rate ranged from 2.9 to 0.25 liters/second (normal is 3 liters/second). The forced expiratory volumes were decreased in all patients as were the maximal voluntary ventilations. All patients showed the ventilatory disturbances characteristic of chronic obstructive pulmonary emphysema (Table II).

### Discussion

The most constant clinical feature in chronic pulmonary emphysema is dyspnea on exertion. The most commonly affected person is a male cigarette smoker, past 40 years of age who develops a cough which is, with very few exceptions, productive. In these 20 cases reviewed, nineteen were cigarette smokers and one was a tobacco chewer; all were past the age of 40 and 18 admitted to having a cough. In approximately 70% of the patients with obstructive pulmonary emphysema reported in American literature, chronic bronchitis is found to be concomitant with or preceding the onset of dyspnea. Most observers favor bronchitis as an inciting

TABLE # 11 - PULMONARY FUNCTION STUDIES IN 20 CASES OF EMPHYSEMA

	Total Vital Capacity	TVC as % Normal	Max. Exp. Flow Rate N = 3 l / sec.	Timed Vital Capacity* 1, 2, 3 sec. (%)	Max. Breathing Capacity	M. B. C. as % Normal
1	1.8 l	75	0.42 l / sec.	50, 62, 73	35.2 l / min.	57
2	1.8 l	52	0.52	45, 65, 80	28.8	33
3	2.3	65	2.1	75, 86, 95	54.0	78
4	2.8	73	1.5	50, 65, 75	56.0	55
5	2.6	--	--	70, 85, 90	61.6	72
6	3.3	95	2.9	55, 76, 90	40.0	67
7	1.7	42	0.25	25, 44, 55	41.3	24
8	2.4	65	0.44	28, 45, 55	26.4	26
9	1.3	36	0.28	54, 70, 86	32.0	34
10	2.2	65	0.54	32, 50, 65	36	38
11	3.0	--	--	45, 65, 75	38	36
12	2.2	58	1.4	58, 74, 85	52.8	49
13	2.0	70	2.0	60, 78, 86	38.4	45
14	1.8	46	0.62	63, 74, 93	48	51
15	2.5	65	0.94	45, 65, 76	57.2	48
16	2.2	60	0.75	53, 65, 75	44	34
17	3.0	83	2.3	60, 85, 95	52.8	55
18	2.6	72	1.9	69, 92, 96	40	41
19	1.7	63	0.56	53, 63, 80	38.4	47
20	2.4	67	1.00	55, 74, 83	38.4	37

\* Normal = 1 sec. = 83%; 2 sec. = 94%; 3 sec. = 97%

factor. Fifteen of the 20 patients presented in this paper had chest films interpreted as chronic bronchitis, mild to moderate, and six of these also had x-ray evidence of emphysema. Of the remaining five, four were read as pulmonary emphysema and one as pulmonary fibrosis. Included with chronic bronchitis as inciting factors were cold, damp weather, dusty working conditions, and an urban environment, all of which may cause hypersecretion of mucus in the bronchial tree. When a patient with chronic bronchitis reaches the stage of dyspnea, this usually signifies either reversible bronchial narrowing due to secretion, bronchospasms, or irreversible obstruction to air flow due to development of destructive emphysema.

In the few studies which have been done, bronchial asthma has been found to rarely progress to obstructive pulmonary emphysema. Five patients in this study gave a history of "asthma." Of these patients, all had physical findings of chronic pulmonary emphysema and pulmonary function studies confirmed this diagnosis. All had chest films interpreted as chronic bronchitis; three of these in turn were interpreted also as showing emphysema.

Pulmonary function studies, in chronic obstructive pulmonary emphysema, characteristically show a

vital capacity which can range from normal to a markedly diminished one with advancement of the disease. Timed vital capacity (forced expiratory volume) is usually decreased, especially during the first second. Normal or average value for the first second forced expiratory volume is 83%; the average for the 20 patients included in this study is 51.8%. The maximum breathing capacity (maximal voluntary ventilation) is likewise reduced. (Table II.) Victims of chronic obstructive pulmonary emphysema usually average a maximal expiratory flow rate below 2 liters/second, normal being 3 liters/second. Patients in this study averaged a maximal expiratory flow rate of 1.2 liters/second.

The American Thoracic Society (1962) divides pulmonary emphysema into five stages of severity: I. Asymptomatic; II. Ventilatory; III. Hypoxia; IV. Hypercarbia; V. Emphysema Heart Disease, (a) compensated and (b) decompensated. The following are used to class the stages: I. Clinical, (a) symptoms, (b) physical signs, and (c) laboratory findings; II. Physiologic, (a) abnormal function tests. The patients presented in this study ranged from Stage II through V.

The English include chronic bronchitis and emphysema under the term chronic diffuse non-specific



lung disease. This is defined by Harrison (1961) as "a condition of chronic cough with sputum production with or without paroxysmal or persistent uncomfortable shortness of breath which cannot be attributed to localized lung disease, general infection, granulomatous, fibrotic or first degree cardiovascular disease, disorders of the chest wall or psycho-neurosis, but may coexist with these and not infrequently does." Chronic diffuse non-specific lung disease has two main divisions: 1) Chronic bronchitis which was defined in the introduction and, 2) Generalized obstructive lung disease which is characterized by a widespread narrowing of the bronchial tree, most commonly on expiration, causing an increase above normal in secretion and resistance to air flow. This diagnosis can be made with certainty by finding a decreased timed vital capacity (or in British terminology, the one second forced expiratory volume—F.E.V.<sub>1.0</sub>).

### Subdivision of Disease

The subdivisions of generalized obstructive lung disease are intermittent or reversible, and persistent or irreversible. The former is almost always bronchial asthma, which shows widespread narrowing of bronchial airways which can change in severity over short periods of time, either spontaneously or with treatment. This excludes cardiovascular disease. The latter refers to widespread narrowing of the bronchial airways and increased airway resistance which has been present for more than one year and which is unaffected by bronchodilator drugs. Most of these patients are found to have emphysema at post-mortem.

The above classifications and definitions used and developed by the British stress the use of functional rather than anatomic clinical diagnosis. These also point out the difficulties in an accurate diagnosis of emphysema. The British, in their classifications, also stressed the various combinations of bronchitis, with reversible and irreversible obstructive lung disease met during a life span.

### Types of Abnormalities

Fletcher (1961) divided the syndrome of chronic bronchitis into three main types of abnormalities. The first is simple chronic bronchitis, characterized by hypersecretion of bronchial mucus, manifest as mucoid sputum over the necessary period of time. The second type is chronic bronchitis with recurrent or persistent infection, manifested by recurrent chest illness and by purulent sputum. A bronchogram may show bronchial dilatation and an American physician would probably call this bronchiectasis. The British

state that localized bronchial dilatation in this instance is of a greater degree than is found in simple bronchitis. The third division is chronic bronchitis with airway obstruction which may cause impairment of ventilatory capacity and dyspnea. There is shortness of breath in this instance because of obstruction to air flow giving rise to impairment of ventilatory capacity. Cigarette smoking was cited as one of the more important etiologic factors in chronic bronchitis in Great Britain.

Mortality attributed to bronchitis, at all ages, is 30 to 40 times as great in Great Britain as it is in the United States. This is possible because of the difference in the use of terminology. G. R. Meneely in his 1960 *JAMA* article, "Cardiopulmonary Semantics" stated that chronic bronchitis is regarded in the United States as a low grade inflammatory process in the bronchial tree associated with a persistent cough, post-nasal discharge, and is often related to smoking. It is thought of as a nuisance rather than a disease. He contends that in Great Britain the term is applied to a common and potentially grave disease associated with bronchial hypersecretion, cough, expectoration, dyspnea, and ultimately by respiratory or cardiac failure. The analogy was made that the British use of the word was more akin to slowly progressive but malignant hypertension, while the United States regards it as a benign type of essential hypertension. The British, according to Meneely, deplore the way the term emphysema is commonly used in the United States when applied to any patient with severe pulmonary disease who displays evidence of chronically over-distended lungs, with increased residual air and expiratory obstruction.

### Pathology

In chronic obstructive pulmonary emphysema, classically the lungs are large and do not collapse when the thorax is opened. Centrilobular emphysema appears to be a complication of generalized emphysema. There is selective and progressive destruction of the respiratory bronchiole in the mid-portion of the secondary lung lobule. Chronic bronchitis is an invariable finding in these lungs. Panlobular is emphysema equally as common. The pathological finding is uniform air membrane distension and fenestrations throughout the secondary lobule. Panlobular emphysema is also common in kyphotic chest deformities, localized hilar scleroses or neoplastic states producing laryngeal or large bronchial airway deformities. Less well-defined is airway obstruction in chronic bronchitis observed in many established cases of panlobular emphysema (Anderson, et al, 1963).

Chronic bronchitis and chronic obstructive pulmonary emphysema are major health problems in this country today. Although both are considered separate entities, it cannot be denied that chronic bronchitis plays an important etiologic role in the production of obstructive pulmonary emphysema. Twenty case histories of patients with chronic obstructive pulmonary emphysema are presented. The diagnosis was initially made by physical findings and confirmed by pulmonary function studies. All patients presented had PA and Lateral chest films.

A review of British and American literature is presented to compare these two entities as they appear clinically. Pathological findings are also included.<sup>1 & 2</sup>

Medical College of Georgia

Special thanks are extended to Dr. Billie LaMotte, our Radiologist, who interpreted all x-rays.

## BIBLIOGRAPHY

1. American Thoracic Society: "Chronic Bronchitis, Asthma & Pulmonary Emphysema. A Statement by the Committee on Diagnostic Standards for Nontuberculous Respiratory Diseases," American Review Respiratory Diseases, 85:762, 1962.
2. Banyai & Levine: *Dyspnea Diagnosis & Treatment*, Philadelphia, F. A. Davis Co., 1963.
3. Barach & Beckerman: *Pulmonary Emphysema*, Baltimore, Williams & Wilkins Co., 1956.
4. Beeson, et al, "Bronchitis & Emphysema: Ventilatory Insufficiency," *Year Book of Medicine* 1963-1964.
5. Ciba Guest Symposium: "Terminology, Definition and Classification of Chronic Pulmonary Emphysema & Related Conditions," *Thorax*, 14:286, 1959.

6. College of General Practitioners: "Chronic Bronchitis in Great Britain," *British Medical Journal*, 2:973, 1961.
7. Fletcher, C. M.: "An Account of Chronic Bronchitis in Great Britain with Comparison Between British & American Experience of the Disease," *Diseases of the Chest*, 44:1, 1963.
8. Fletcher, C. M., et al: "The Significance of Respiratory Symptoms & Diagnosis of Chronic Bronchitis in a Working Population," *British Medical Journal*, 2:257, 1959.
9. Fletcher, C. M., Hugh-Jones, P., et al: "The Diagnosis of Pulmonary Emphysema in Presence of Chronic Bronchitis," *Quarterly Journal of Medicine*, 32:33, 1963.
10. Fletcher, C. M. & Tinker, C. M.: "Chronic Bronchitis. A Further Study of Simple Diagnosis in a Working Population," *British Medical Journal*, 1:1491, 1961.
11. Harrison, T. R., et al: *Principles of Internal Medicine*, New York, McGraw-Hill Book Co., 1960.
12. Leopold, J. G. & Gough, J.: "The Centrilobular Form of Hypertrophic Emphysema and Its Relation to Chronic Bronchitis," *Thorax*, 12:219, 1957.
13. Medical Research Council: "Standardized Questionnaire of Respiratory Symptoms," *British Medical Journal*, 2:1665, 1960.
14. Meneely, G. R., et al: "Cardiopulmonary Semantics," *JAMA*, 174:1629, 1960.
15. Muir, M. D.: "Mucoviscidosis & Adult Chronic Bronchitis," *Lancet*, 1:181, 1962.
16. Naclerio, E. A., *Bronchopulmonary Diseases Basic Aspects of Diagnosis & Treatment*, New York, Hoeber-Harper Book Co., 1959.
17. Reid, L. McA.: "Measurement of the Bronchial Mucous Gland Layer: A Diagnostic Yard Stick in Chronic Bronchitis," *Thorax*, 15:132, 1960.
18. Seeborn, M. & Bedell, G. N.: "Primary Pulmonary Emphysema in Young Adults," *American Review Respiratory Diseases*, 87:41, 1963.
19. Vance, J. W.: "Respiratory Exchange During Exercise in Patients with Diffuse Obstructive Pulmonary Emphysema," *Diseases of the Chest*, 42:191, 1962.
20. Williams, J. W.: "Pulmonary Function in Farmer's Lung," *Thorax*, 18:255, 1963.
21. Wyatt, J. P., et al: "Panlobular Emphysema; Anatomy & Pathodynamics," *Diseases of the Chest*, 41:41, 1962.

# MENINGITIS GO GO GO

Now is the time for all good etymologists to come to the aid of semantically bedeviled health officers. To come straight to the point, I want to do away with the word MENINGITIS. In its natural habitat this word is quite harmless. In hospitals or clinics or medical schools it is docile and performs its duties as any well trained medical word should. But with a change of environment it undergoes an appalling metamorphosis. For example, release it in a schoolroom: pupils, teachers, and parents are immediately seized with apprehension, dread, and downright terror. And the hapless health officer is caught in a crossfire of frenzied entreaty and reproof.

No lay person can hear the word MENINGITIS pronounced without losing his reason completely. To be sure, the doctor said ASEPTIC meningitis. But MENINGITIS registered; nothing else. That combina-

tion of sounds conjures up visions of wholesale illness and sudden death. Explanation and reassurances avail little. Only several uneventful days assuage fears and leave the health officer a shadow of his former self.

## Another Expression

If only this word could be eliminated from our vocabulary and some other expression, just anything, made to serve. I have tried to come up with something, such as—CRANIAL MEMBRANITIS or CENTRAL INFLAMMATORY NEUROPATHY. You can see I need help. As I said in the beginning, now is the time, etc.

This diabolical word MENINGITIS has got to go.

Ernest Thompson, M.D., Marietta  
Cobb County Health Department  
410 Fairground Street



# SEROUS OTITIS MEDIA

E. F. Staats, M.D., *Atlanta*

- **A marked increase in the incidence of this condition has been noted in recent years.**

**AN** INEXCUSABLE portion of our child population has a hearing loss of mild or moderate degree caused by Serous Otitis Media. Serous Otitis Media is a disease of the middle ear and eustachian tube characterized by an accumulation of fluid in the tympanic cavity associated with tubal obstruction. There are many synonyms in the literature—exudative middle ear catarrh, hydrotyimpanum, acute non-suppurative otitis media, acute salpingitis, otitis media ex-vacuo, secretory catarrh, secretory otitis media, and serous otitis media.<sup>1</sup>

## Becoming More Important

In the ever broadening field of otolaryngology, this old disease seems to be becoming more important.<sup>2</sup> Our knowledge of Serous Otitis Media leaves much to be desired, although moderate progress is being made in the research field. Treatment at present is satisfactory, but could be improved. The signs and symptoms are relatively clear cut, and the diagnosis is made mainly on the alertness and awareness of the examiner. The importance of this disease is easily recognized when one realizes that the largest group of sufferers are children who will characteristically show mild to severe hearing loss impeding them in their development and learning. Today more than ever, the alert Serous Otitis Media conscious examiner must search for and attempt to eradicate this ubiquitous disease.

Politzer is given credit in 1869 for the first clear description of Serous Otitis Media, but there were many other forerunners.<sup>3,4</sup> The literature concerning Serous Otitis Media is rather sparse until the early 1940's when several good reports were presented by Hartman, Hoople, and Engle.<sup>5,1,6-8</sup> Then in the 1950's up until the present time, our journals are found to contain many articles on this problem.

*From the Department of Otolaryngology, Emory University School of Medicine, Grady Memorial Hospital.*

*Pediatric Staff Conference, Eggleston Hospital, Atlanta.*

The incidence of Serous Otitis Media reported around the country is definitely higher than it was ten to fifteen years ago.<sup>9-10</sup> Whether this is real or apparent remains open to question. Most investigators are of the opinion that the wide-spread use of antibiotics has caused an increased incidence by converting the purulent ear into the fluid aseptic ear.<sup>12,1,9</sup> The present ultraconservative feeling regarding tonsillectomy and adenoidectomy among pediatricians may play an important role.<sup>13</sup> Increased awareness certainly has a part.<sup>13,1</sup>

The age of patients ranges from one to 80, but the largest majority are less than eight years of age.<sup>14</sup> Armstrong reports that out of 6,000 cases, 80% were eight years old or less and 9% were from nine to sixteen.<sup>15</sup> This has become in some clinics the most common otologic diagnosis made.<sup>10,14</sup> Various hearing clinics report that Serous Otitis Media represents 25% of all cases seen.<sup>9</sup>

The patient's history is most commonly one of a recent upper respiratory infection.<sup>12</sup> He may relate an episode of otitis or tonsillitis treated with antibiotics. Typical adenoid symptoms of snoring, mouth breathing, and nasal voice are frequently found. The patient may give a history of nasal allergy with sneezing and seasonal rhinitis. The mother commonly says her child pulls at his ears, is restless, and does not hear well. An episode of recent barometric trauma may rarely be mentioned. Often no significant prior history can be elicited.

## Varying Symptoms

The symptoms of Serous Otitis Media may be most distressing or nonexistent—depending on the individual case.<sup>10,16,6</sup> Most complaints will center around the hearing impairment caused by the middle ear fluid.<sup>13,15</sup> A typical patient will say, "My ears feel stuffy or blocked. They are like a piece of wood. Lifeless. My hearing is lopsided, and I have a rolling in my ear." A very common complaint is

one of a sensation of speaking through the ear, or that one's head is in a barrel. The sensation of crackling, water bubbling and squeaking in the ear is frequent. Tinnitus, when present, is of a low pitch.<sup>9</sup> Mild dizziness occurs sometimes. Pain is rarely present, and when it is found, it is only minor. A decrease in hearing related to head positions is sometimes seen. A story of sudden failure to do well in school may be the only symptom. There is seldom any systemic response.<sup>17</sup>

### **Inspection of Ear Drums**

The signs of Serous Otitis Media are mainly those of inspection of the ear drums.<sup>18</sup> Disease is found bilaterally in approximately 70% of reported cases.<sup>12,13</sup> The external ear and canal are normal. The tympanic membrane does not appear normal.<sup>12</sup> Its color, contour, landmarks, and bones are changed. Each case is different, but all characteristically show a retracted drum with a dispersed light reflex; a prominent short process of the malleus with foreshortening of the long process; the posterior fold is prominent and white to grey in color with a sharp edge.<sup>19</sup> The color of the drums is usually amber or yellow, but this varies greatly.<sup>12</sup> The spectrum can range from a tan to a bluish hue. Some drums reveal a brawny appearance or may even be opaque in cases of long standing. The transparency of the drums in Serous Otitis Media is most commonly increased and gives the impression of being oiled or buttered.<sup>19</sup> Fluid levels are seen in less than 50% of patients.<sup>9</sup> Some say fluid levels are found in as low as 10%.<sup>10</sup> This level is usually yellow to creamy in color but may be brown to a dark blue. The level commonly looks like a black hair line. The amount of fluid present may be so sparse as to only fill the hypotympanum or may fill the entire tympanic cavity. Usually, however, it is only partially filled, and a level or bubbles can be seen. The levels of fluid may be straight, curved, or segmented. They seek the dependent position. The fluid can be manipulated and caused to create bubbles with the pneumatic otoscope or with eustachian inflation.

### **Limited Excursion**

The excursion of the drum is limited with the pneumatic otoscope ranging from complete immobility to quadratic movement due to adhesions. Limitation of this drum movement can also be demonstrated with the Valsalva or Toynbee maneuver. Characteristically crackling sounds can be demonstrated with the Toynbee tube or increased sound

transmission can be heard by using the tuning fork or the patient's voice.<sup>15</sup>

If suspicion is high enough, a diagnostic myringotomy can be performed with the finding of fluid.<sup>9</sup>

Other associated signs of Serous Otitis Media are the very frequent findings of hypertrophy of tonsils and adenoids; evidence of an allergic nasal mucosa; nasal polyps; nasopharyngeal tumor; sinusitis; dental malocclusion; and the general signs of hypothyroidism.<sup>10,7,12</sup>

Hearing tests may bring the patient to the attention of the otorhinolaryngologist and functionally are the most important.<sup>15,20</sup> A loss of hearing is found of a conductive type.<sup>21</sup> This can be elicited by finding a negative Rinne at 128 and 256. A decreased Schwabach and lateralization of the Weber when disease is unilateral is found. Word discrimination is good, denoting a conductive loss. Audiograms usually show a low frequency hearing loss from 5 to 30 decibels, but a loss is very marked in some cases.<sup>12</sup> A few cases will reveal a high tone loss from 10 to 45 decibels. A nerve lesion may be diagnosed because of decreased bone conduction which is explained on the basis of fixation of the windows by fluid or adhesion.<sup>42</sup>

### **Fluid Varies**

The character and chemistry of the middle ear fluid varies.<sup>22,23</sup> The physical nature of the effusion ranges from a watery serous fluid to a thick mucoid or so-called "glue ear."<sup>24</sup> The fluid is usually sterile, but some recent reports find bacteria present in a significant percentage.<sup>25</sup> The amount of cellular material in the fluid closely correlates with an increased viscosity.<sup>26</sup> The protein content of the material is about the same in all types. Increased amounts of DNA and mucopolysaccharide are present in the mucoid ears.<sup>24</sup> When all cells and debris are removed from the fluid, all are relatively the same and have no consistent difference electrophoretically. The pattern is almost the same as that of blood sera in most samples.<sup>26</sup> The presence or absence of eosinophiles remains controversial.<sup>24,1</sup> Some studies report high numbers while others find none.<sup>3,23,9</sup>

The etiology of Serous Otitis Media has not been fully elucidated. Why one individual has Serous Otitis Media may differ widely from why another has it.<sup>9</sup> A great deal of controversy and question exists and grows as more is learned. It is generally agreed that the fundamental cause is eustachian tube obstruction, but whether this is the ultimate primary cause remains to be discovered. Conditions promoting this dysfunction, or seen in correlation with it, are varied. Hypertrophy of tonsils and ade-



noids remains the single most important finding at present.<sup>11</sup> Recurrent upper respiratory infection, both viral and bacterial, are commonly found in the history.<sup>1</sup> Allergy primarily, and allergy to local bacterial toxins play a role, but just how important a role is open to controversy. Some feel allergy in whatever form is the primary cause and can recite many studies to support their feeling.<sup>16,27</sup> Sinusitis may be seen in a number of cases.<sup>7</sup> The inherent anatomy of the individual must be considered. Other more infrequent but important causes are nasopharyngeal tumor, dental malocclusion, aero-otitis, deviated septum, improper blowing of nose, cleft palate, neurological or functional abnormalities of the palatal or pharyngeal muscles, functional and allergic rhinitis, hypothyroidism, viral disease,<sup>17</sup> and possible obstruction of the hypotympanum.<sup>9,28,19,27</sup>

### Pathogenesis

The pathogenesis of Serous Otitis Media at present is not fully understood. The existence of many ideas and only a few facts leads to an unclear picture of the process. Eustachian tube obstruction is certainly one of the earliest findings.<sup>1</sup> The primary factor in the individual case is frequently supposition, but it is almost always accompanied by altered tubal physiology. With this obstruction we find a relative vacuum being created in the middle ear associated with changes in the mucosa of the tympanic cavity.<sup>29</sup> The fluid that is then produced apparently comes from several sources. It may be an infectious exudate, a transudate from the hyperemic mucosa and vessels, a secretion of goblet cells of the middle ear formed through metaplasia, or a retrograde flow of secretions from the tubal glands. Its presence along with the inflammatory process accompanying it leads to further changes in the mucosal lining which can cause fibrosis and ultimate fixation of the middle ear parts. This full cycle of events does not usually occur, but may stop at any stage or "burn itself out" with resolution of the fluid by absorption and drainage.<sup>22</sup>

The author feels the most effective treatment of Serous Otitis Media must do five things:

- (1) Eradicate the etiology when known—i.e., hypothyroid, nasal tumor, etc.
- (2) Restore normal tubal function.
- (3) Remove all fluid from the middle ear.
- (4) Eliminate all adhesive processes.
- (5) Re-establish a normal mucosa to the tympanic cavity and auditory tube.

To arrive at these goals in a given case may be quite easy or only partially successful—and in some

cases, impossible. Therapy will depend on the extent of disease and its probable cause. The most conservative measures may suffice in some cases, while a few but significant number may come to radical treatment. A period of watchful expectancy is warranted in all cases, but when the disease is of weeks or months duration, certainly definitive treatment must be initiated. Since children remain numerically the largest group of cases at present, we have found that adenoidectomy or adenoidectomy combined with tonsillectomy offers them a very high percentage of cure.<sup>30-32</sup> Most surgeons will in addition perform a myringotomy and suction the middle ear contents.<sup>33,34</sup> Treatment without removal of hypertrophic adenoids has been shown in all series to be quite disappointing and related to a high recurrence rate. (Two to four times the number of recurrences.)<sup>12,27</sup> Recently myringotomy has been combined with the insertion of a prosthesis of polyethylene or teflon tubing in the drum to keep the middle ear open.<sup>35,15,27,36</sup> Some use this in all cases, while others use it only in the more resistant patients. Office therapy with politerization of the tympanic cavity and middle ear massage with the pneumatic otoscope combined with or without myringotomy is often effective in some selected cases.<sup>31</sup> Many physicians instruct their patient in home auto-inflation by Politzer, Toynbee, or Valsalva techniques.<sup>37</sup> Encouraging papers have been presented on various medical treatments such as Trypsin, vasoconstrictors, antihistamines, and steroids.<sup>38-41</sup> They are no panacea to Serous Otitis Media, but should be used when indicated in conjunction with good surgical management.<sup>24</sup> The allergic individual poses a frequent resistant case and should be given the usual allergy regime of desensitization combined with removal of hypertrophic lymphoid tissue.<sup>27</sup> Radiation may be indicated in some very few cases.<sup>10</sup> In all large series of patients, there are always a few who resist therapy and ultimately come to some type of mastoid procedure.<sup>1,27</sup>

### Prognosis Good

The prognosis in most cases is very good, and in any large series approaches 90% cure.<sup>31,32</sup> In the individual patient certain factors can alter this cure rate. The allergic patient is often difficult to manage.<sup>27</sup> Those with history of long standing disease and those with a "glue ear," or mucoid exudate, have a decreased prognosis. Patients with cleft palate and neuromuscular abnormalities present constant problems.<sup>42</sup>

Serous Otitis Media is an old disease that has shown a marked increase in the last 15 years, especially among children.<sup>8,10</sup> It is relatively easy to



diagnose in most cases when one is aware of the disease and is alert to its signs and symptoms.<sup>43,44</sup> Answers are being constantly found in the areas of etiology and pathogenesis. Treatment of this process is good in most cases and usually results in a normally functioning ear. This is a debilitating disease that is both interesting and provocative and is certainly one that warrants our close and continuing attention.

## BIBLIOGRAPHY

1. Suehs, Oliver W.: Secretory Otitis Media. *The Laryngoscope*, 62:998-1027, September, 1952.
2. Hoople, G. D.: Otitis Media with Effusion: A Challenge to Otolaryngology. *Tr. Am. Acad. Ophth.*, 54:513-539, 1949.
3. King, James T.: The Condition of Fluid in the Middle Ear. *Ann. Otol., Rhin. & Laryng.*, 62:495-506, 1953.
4. Politzer, A.: *Diseases of the Ear*, 5th Edition: 1909; Balliere, Tindall & Cox.
5. Hoople, G. D.; Bradley, W. H.: Fluid Ears and Nerve Deafness Circa 1835. *The Laryngoscope*, 68:716-722, 1959.
6. Shahinian, L.: Fluid in the Middle Ear. *Arch. Otolaryng.*, 38:328-337, 1943.
7. Hoople, G. D.; Blaisdell, I. H.: The Problem of Acute Catarrhal Otitis Media. *Ann. Otol., Rhin. & Laryng.*, 52:359-363, 1943.
8. Eagle, W. W.: Secretory Otitis Media. *Trans. Am. Laryngol., Rhinol. and Otol. Soc.*, 23:37, 1946.
9. Bell, H. L.: Management of Secretory Otitis. *EENT Monthly*, 40:614-618, 1961.
10. Freeman, M. S.: Serous Otitis Media. *Am. Jour. Dis. Child.*, 99:683-687, 1960.
11. Lake, C. F.: Tonsillectomy, Adenoidectomy & Myringotomy in the Treatment of Secretory Otitis Media in Children. *Proc. Staff Meet. Mayo Clinic*, 33:375-380, 1958.
12. Lemon, A. N.: Serous Otitis Media in Children. *The Laryngoscope*, 72:32-44, 1962.
13. Theobald, P. W.: Secretory Otitis Media in Children. *Arch. Otolaryng.*, 68:737-747, 1958.
14. Armstrong, B. W.: Chronic Secretory Otitis Media, Diagnosis and Treatment. *Southern Medical Journal*, 50:540-546, 1957.
15. Armstrong, B. W.: Secretory Otitis Media—Problems & Pitfalls. *Jour. A.M.A.*, 179:505-509, 1962.
16. Hosen, Harris: Relationship of Allergy and Infection to Secretory Otitis Media. *Texas State Jour. of Medicine*, 55:257, 1959.
17. Fishman, L. Z.: Indolent, or so-called Serous Otitis Media. *Arch. Otolaryng.*, 72:25-30, 1960.
18. Hautman, I.: Secretory Otitis Media. *Arch. Otolaryng.*, 88:561-573, 1943.
19. Tremble, G. E.: Secretory Effusion of the Tympanum. *The Laryngoscope*, 61:791-802, 1951.
20. Kapur, Y. P.: Serous Otitis Media in Children. *Arch. Otolaryng.*, 79:38-48, 1964.

21. Lemon, A. N.: Serous Otitis Media in Children. *Arch. Otolaryng.*, 68:567-573, 1958.
22. Senturia, B. H.; Carr, Charles D.; Ahlvin, Robert C.: Middle Ear Effusion; Pathologic Changes of the Mucoperosteum in the Experimental Animal. *Trans. Amer. Otol. Soc., Inc.*, 50:33-48, 1962.
23. Senturia, B. H., et al: Studies Concerned With Tubo-tympanitis. *Ann. Otol., Rhinol., and Laryngol.*, 62:440-467, 1958.
24. Senturia, B. H.: Middle Ear Effusions: Causes & Treatment. *Trans. Am. Acad. Ophth.*, 64:60-72, 1960.
25. Sade, J., et al: Middle Ear Effusions Produced Experimentally in Dogs: Microscopic & Bacteriologic Findings. *Ann. Otol., Rhinol., and Laryngol.*, 68:1017-1027, 1959.
26. Gessert, C. F., et al: Middle Ear Effusions Produced Experimentally in Dogs: Biochemical & Electrophoretic Properties. *Ann. Otol., Rhinol., and Laryngol.*, 68:1028-1036, 1959.
27. Boor, S. V.: Management of Serous Otitis Media in Children. *Arch. Otolaryng.*, 75:130-137, 1962.
28. Compere, W. E.: Tympanic Cavity Clearance Studies. *Tr. Am. Acad. Ophth.*, 62:444-454, 1958.
29. Jordan, R. E.: Secretory Otitis Media in Etiology of Cholesteatoma. *Arch. Otolaryng.*, 78:261-265, 1963.
30. Singleton, J. D.: Serous Otitis Media. *Tr. Am. Lar. Rhin. Otol. Soc.*, 308-318, 1956.
31. Gottschalk, G. H.: Serous Otitis Treatment by Controlled Middle Ear Inflation. *The Laryngoscope*, 72:1379-1390, 1962.
32. Hays, A. V.: Adenoid Revision. Its Importance in the Treatment of Serous Otitis Media in Children. *The Laryngoscope*, 71:1402-1418, 1961.
33. Stevens, J. M.: Long Term Effects of Serous Otitis. *Lancet*, 2:216-218, 1962.
34. Jay, H. M.: Aspiration Thorough the Tympanic Membrane. *Jour. Laryngol. and Otol.*, 55:385-386, 1940.
35. Armstrong, B. W.: A New Treatment for Chronic Secretory Otitis Media. *Arch. Otolaryng.*, 59:653-654, 1954.
36. Pang, L. Q.: A New Procedure for Removing Fluid from the Middle Ear in Cases of Serous Otitis Media. *Arch. Otolaryng.*, 69:466-467, 1959.
37. Rawlings, A. G.: Chronic Secretory Otitis Media in Adults: A Satisfactory Treatment. *Tr. Am. Acad. Ophth.*, 58:427-431, 1954.
38. Heisse, J. W.: Secretory Otitis Media: Treatment with Depo-Methylprednisolone. *The Laryngoscope*, 73:54-58, 1963.
39. Gessert, C. F., et al: The Action of Enzymes on Human Middle Ear Effusions. *Ann. Otol., Rhinol. and Laryngol.*, 69:936-955, 1960.
40. Weeks, D. J.: Secretory Otitis Media and Nasal Allergy. *Arch. Otolaryng.*, 68:748-751, 1958.
41. Auslander, M. M.: Serous Otitis Media: Treatment with Injectable Trypsin. *Arch. Otolaryng.*, 67:24-27, 1958.
42. Graham, Malcolm: A Longitudinal Study of Ear Disease and Hearing Loss in Patients with Cleft Lips and Palates. *Ann. Otol., Rhinol., and Laryngol.*, 73:34-47, 1964.
43. Singleton, J. D.: Serous Otitis Media. *The Laryngoscope*, 66:293-303, 1956.
44. Hoople, G. D.: Otitis Media with Effusion—A Challenge to Otolaryngology. *The Laryngoscope*, 60:315-329, 1950.

## MEDICAL COLLEGE OF GEORGIA RECOGNIZES GEORGIA'S LONG-PRACTICING PHYSICIANS

The Medical College of Georgia, Augusta, has recently recognized 254 Georgia physicians who have practiced medicine for 50 years or more, or who are over 75 years of age. Each will be presented with an acknowledging certificate which will entitle him to complimentary enrollment in all continuing medical

education courses offered by the Medical College. Each certificate will read, "In Grateful Acknowledgement of Outstanding Service in the Practice of Medicine," and will carry the signatures of the doctor, the Dean of the School of Medicine and the President of the Medical College.



# For Your MAG 1965 Annual Session Hotel & Motel Reservations

APPLICATION FOR HOTEL AND MOTEL ACCOMMODATIONS  
Medical Association of Georgia 111th Annual Session  
May 2-4, 1965 — Augusta, Georgia

A HOUSING BUREAU has been established for your convenience in making hotel and motel reservations at Augusta for the 1965 Annual Session of the Medical Association of Georgia. Comparable room rates and accommodation information are listed. *Use the Reservation Form below.* Please specify your first, second and third choice hotel or motel. All requests for reservations should give: (1) anticipated date and hour of arrival; (2) date and approximate hour of departure; (3) names and addresses of all persons who will occupy the accommodations. All reservations must be cleared through the Housing Bureau. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible to secure the accommodations you request. All reservations will be confirmed.

**Augusta Town House:** Broad at Albion St. (722-5541). **Single \$7 up, double \$8.50 up, twin beds \$9.50 up.** 100% Air Conditioned, Swimming Pool, TV-Radio, Free inside parking, barber and beauty shop, two cocktail lounges, two restaurants, newstand, Gift Shop, package shop — Heart of Augusta — 300 Rooms.

**Downtowner Motor Inn:** Reynolds at 8th St. (722-5361). **Single \$8 up, double \$10.50 up, twin beds \$12.00 up.** 100% Air Conditioned, Radio — TV, Free parking. Swimming pool, Cocktail Lounge, Restaurant — 100 rooms.

**Warrick — Quality Motel:** Broad at 4th St. (722-0212). **Single \$8 up, doubles \$10, twin beds \$12.** Air Conditioned — TV, Free Parking, Free Continental Breakfast. Cocktail Lounge — 69 Rooms.

**University Motel:** 1410 Gwinett St. (724-8204). **Single \$7 up, double \$9 up, twin beds \$10 up.** Air Conditioned.

— TV, Free parking, Restaurant near-by, Adjacent Talmadge Memorial and University Hospitals — 68 Rooms.

**Medical Center Motel:** 1480 Gwinett St. (722-4828). **Single \$7 up, double \$9 up, twin beds \$10 up.** Air Conditioned — TV, Free Parking, Restaurant next door, Adjacent Talmadge Memorial and University Hospitals — 45 Rooms.

**Howard Johnson Motor Lodge:** 1238 Gordon Highway. (724-9613). **Single \$9 up, double \$12 up, twin beds \$13.** Air Conditioned — TV, Swimming Pool, Free parking, Restaurant and Cocktail Lounge — 61 Rooms.

**Holiday Inn:** 1602 Gordon Highway. (798-2782). **Single \$7 up, double \$11 up, twin beds \$11 up.** Air Conditioned — TV, Swimming Pool, Restaurant, Cocktail Lounge, Free Parking — 110 Rooms.

Confirmation of your request for accommodations will be in accordance with preference indicated, if possible; if not, best substitutes will be made.

Cut out and send to: Please Type or Print  
HOUSING BUREAU, MEDICAL ASSOCIATION OF GEORGIA  
Augusta Town House, Augusta, Georgia — Attn: Otis Phillips, Vice-President — Sales  
Please reserve the following accommodations for the 1965 Annual Session of the  
Medical Association of Georgia.

Hotel or Motel Preference

1st Choice _____	<input type="checkbox"/> Double Room at \$ _____ to \$ _____
2nd Choice _____	<input type="checkbox"/> Double Room at \$ _____ to \$ _____
3rd Choice _____	<input type="checkbox"/> Twin Bedroom at \$ _____ to \$ _____
	<input type="checkbox"/> Other type _____

Arrival Date _____	Hour _____	A.M.	P.M.
Departure Date _____	Hour _____	A.M.	P.M.

THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Include all names of all persons for whom you are requesting reservations and who will occupy the room(s):

Name of Occupant(s)	Address
_____	_____
_____	_____
_____	_____

Individual Requesting Reservations

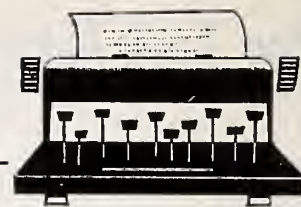
Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

If hotels or motels of your choice are unable to accept your reservations, the Housing Bureau will make reservations to fit your specifications elsewhere.



## The T3 Test

IN THE continuing search for more useful thyroid function tests, one encounters with increasing frequency references to the resin adsorption of iodine-131 tagged triiodothyronine—the T3 test.

What is the T3 test and what are its capabilities?

Protein binding of thyroid hormones has long been known. Specificity of this binding was demonstrated in 1956 with the isolation of a thyroxine-binding globulin which migrates between the alpha-1 and the alpha-2 globulin when subjected to electrophoretic current in Veronal buffer at PH 8.6. Subsequent studies utilizing different electrophoretic techniques have shown a second specific protein migrating in a pre-albumin band. This moiety binds thyroxine, but not triiodothyronine. As is true of many compounds, thyroid hormones are loosely bound to albumin in amounts equal to about five per cent of the quantity bound to thyroid-binding globulin (TBG). When all the specific protein binding sites are saturated, the thyroid hormones then participate in “spill over” binding to a variety of available sites. Here lies the basis for the T3 test.

### Technical Aspects

The technical aspects of the test involve the incubation of test serum with radioactive triiodothyronine followed by incubation with an adsorbing particle. After a lapse of sufficient time for partition to occur between the foreign particle and the thyroid binding globulin, the adsorbing particles are washed and counted. The test is reported in terms of per cent of added iodine-131 labeled triiodothyronine which is resin bound.

The extent of resin adsorption of I-131-triiodothyronine varies inversely with available or unused binding sites of the thyroid binding globulin and varies directly with the concentration of protein-bound endogenous triiodothyronine and thyroxine. For example, in hypothyroid patients a low concentration of endogenous T3 and T4 exists on the circulating thyroid binding globulin. During the test, much of the added triiodothyronine is protein bound and less is bound to the resin. The resin uptake of triiodothyronine then is lower in this instance than that in euthyroid or hyperthyroid subjects. The

values vary between laboratories, but euthyroid subjects usually reveal approximately thirty per cent resin uptake while hyperthyroid subjects reveal about forty-five per cent and hypothyroid around twenty-five per cent. There is some overlap between all three groups.

### Major Advantages

There are two major advantages to the T3 resin uptake procedure. Since iodometry is not involved, the test is not disturbed by the presence of non-thyroidal iodine. Secondly, in this *in vitro* procedure, the radioactive materials are not administered to patients; therefore, children and pregnant women may be tested and repetitive tests may be safely done.

The disadvantage of the test is a technical one. The binding of I-131 T3 depends upon the character and size of the participating resin particles, the PH level at which the test is performed and circumstances of the centrifuging and washing operations. Care must be exerted to subject this procedure to vigorous quality control measures. It is the disregard for the need for this quality control which explains many of the confusing reports obtained from the clinical laboratory.

The I-131 T3 absorption test is erroneously low in pregnancy, in patients being treated with estrogens and in patients receiving certain oral contraceptives.

High values are reported in patients with nephrotic syndrome, patients receiving androgen therapy and in instances of high blood levels of diphenylhydantoin (Dilantin®). Patients receiving inorganic iodides or recently having been given iodine containing x-ray contrast media apparently give dependable results.

### Competitive

The accuracy of the T3 test is competitive with other thyroid function tests. Quimby reports four per cent of her euthyroid subjects to have been placed in a category inconsistent with their clinical picture by this test. Seven per cent of the hyperthyroid patients and eleven to fourteen per cent of the hypothyroid patients were mislabeled. In her hands the T3 test was two to three times more



dependable than the PBI or 24 hour thyroid uptake of iodine 131. As is true with most thyroid function

tests ambiguity is most severe in the hypothyroid range.

Roy Wiggins, M.D.  
727 Juniper Street, N.E.

## A Welcome to Old Friends

THE EDITORIAL STAFF and the Publications Committee would like to welcome back to our Journal advertising pages two of the nation's outstanding ethical pharmaceutical manufacturers, J. B. Roerig

& Co. and the Armour Pharmaceutical Co. This support and confidence shown in our Journal and its readers is much appreciated.

## Medical Education and the Practicing Physician

THE "GEORGIA Medical Education Conference," sponsored by the Medical Association of Georgia, the Medical College of Georgia and Emory University School of Medicine was held January 29-31, at Callaway Gardens. Dr. Thomas W. Goodwin, Augusta, Chairman of the MAG Board of Medical Education, emphasized several points in his opening address which were to serve as guidelines for the meeting. Discussion groups, composed of medical educators and practitioners throughout Georgia, came up with some sound ideas and suggestions for improved medical education in the following areas:

- (1) "Town and Gown" relationships
- (2) Undergraduate Medical Education
- (3) Intra-communication between practicing physicians and medical schools
- (4) Continuing Postgraduate Medical Education at off-campus locations
- (5) General Practitioner Postgraduate Residencies at non-university general hospitals

It was felt that many of the problems which now exist were being soundly studied and dealt with, and adequate solutions were being devised. The fact that the Conference was initially held and well attended was deemed to be an important step toward liaison between "town and gown."

A quote from a summary of the meeting captures the spirit and feeling of the Conference:

"It was generally agreed that good medical care requires medical educators and medical practitioners to work in concert, and if this accord is not reached, problems may develop which can be disruptive to both teaching and practice. It was also suggested that the achievement of this coordinated effort de-

pends to a significant degree on an understanding by both the academic and practicing communities.

"Thus, it was felt important that the practitioner understand the problems of: financial support, the role of research, and the place of speciality teaching and training. Similarly, it was felt to be important that the medical schools understand the needs of the practicing physician in terms of: practical and convenient continuing education, an opportunity for participation in teaching, and efficient consultations for the particularly difficult patient. There seemed to be a consensus that with effective communication and real understanding between these two groups, some items that appear to be problems might turn out not to be problems at all, but simply areas of misunderstanding or misinformation.

"Thus, while recognizing that communication alone would not automatically clear all grey areas or fully exploit all opportunities, it was agreed that this was an enormously important first step."

From the interest and enthusiasm demonstrated by the participants, it would appear that this conference, the first of its kind ever held in Georgia, was a real success. The ground was broken for future useful discussion between practicing physicians and those physicians engaged in full time academic medicine. Both groups may be expected to profit by a widening and a continuing of the contacts initiated at this Conference. To this end, medical education in Georgia will ultimately be improved and better coordinated to fill the needs of the practicing physician within the state.

The MAG President and the Chairman of the Medical Education Board deserve our hearty congratulations for initiating this ambitious program with our fine medical schools.

## Response to Journal Questionnaire

THE STAFF and Publications Committee of the Journal wish to thank all those members who were so kind to respond to the questionnaire which appeared in the January, 1965 issue. In all, more than 300 questionnaires were returned. Those responding embraced all specialties with a good majority coming from those members in general

practice. From this wide sampling of opinion, many useful suggestions were received which will be helpful in guiding the future plans for the Journal.

For those members who have not yet returned our questionnaire, we would be pleased to receive any suggestions you may have at any time.

## State Legislative Wrap-up for 1965

THE LAST of the rurally dominated Georgia legislatures, following an often stormy nine week session, departed the capitol in mid-March for home and the biennial political campaign to retain their old seats in the House of Representatives.

Obviously preoccupied with a record State budget of \$1.2 billion and court ordered reapportionment, the General Assembly was slow getting cranked-up to face the myriad problems and issues before them.

In the House there were 704 bills, and 311 resolutions introduced. Of the various subject matter dealt with in these legislative proposals, the Medical Association of Georgia was primarily concerned with only eleven. Of these eleven MAG favored passage of five and opposed the remaining six. These bills were:

*The Appropriations Act*, in which MAG sought, unsuccessfully, an additional \$1.2 million for the 1965 implementation of the MAA phase of Kerr-Mills. A like amount was appropriated for the 1966-67 year and Georgia is now due to initiate MAA Kerr-Mills in July, 1966.

*A Child Abuse Bill* providing for the mandatory reporting of all suspicious cases of non-accidental child abuse by physicians, osteopaths, residents and interns and others. This bill, which grants both civil and criminal immunity to those required to make such reports, was sponsored by MAG and was enacted into law.

*Voluntary Sterilization*, a bill to establish the legal machinery necessary for the performance of sterilization procedures passed in the House overwhelmingly. It died in the Senate Committee on Health and Welfare on the next to the last day of the session,

however, as a result of religious opposition raised to its provisions.

*Osteopathy*: A bill to grant full practice privileges to osteopaths was defeated in the House Hygiene and Sanitation Committee. In a conference with the Governor and legislative officials and representatives of the Georgia Osteopathic Association, MAG agreed to conduct exploratory talks with the osteopaths prior to the next session of the General Assembly.

*A Marriage Bill* providing for a mandatory three day waiting period, parental consent for under aged minors, and physician proof of pregnancy was offered with the support of MAG. The bill was materially watered down before final passage, to the extent that the three day waiting period will not apply to anyone over age 21.

*A Post Mortem Bill*, which would have seriously hampered medical education both on the medical school and hospital level was passed by the House but "bottled-up" in the Senate Judiciary Committee.

*Driver's License Exam*: A series of traffic safety bills was introduced in the House including an MAG sponsored proposal to require all persons age 65 and over to submit to a driver's license examination every five years. This bill failed of enactment, due in part to the furor caused by the automobile inspection law passed at the previous session.

*Fluoridation* of Atlanta's water supply set off a mild storm in the House after somewhat clearer sailing in the Senate. The crucial vote came on a Conference Committee Report which provided for a public referendum on the issue on petition of 15% of the registered voters of the City of Atlanta. After having passed in the Senate the Conference Report



ran into trouble in the House. A second Conference Report which shaved the petition requirements down to 10% of the registered voters of the City also failed on the night of the last day of the session.

*Basic Science Board Bill.* A bill, introduced by the same representative who introduced the full practice privilege bill for osteopaths, would have created a Basic Science Board whose purpose would have been to test all M.D.'s, D.O.'s and chiropractors seeking licensure for the first time, in the basic sciences. The bill was obviously drawn to create an illusion of equality between physicians and osteopaths. It was "killed" in the House Committee on the University System.

*A Cost of Care (Family Responsibility) Bill* to

permit the State to assess charges for professional services rendered at the Milledgeville State Hospital and other State institutions was offered in the House. It failed to attract much support and died accordingly in Committee.

Under normal conditions all bills which remain in Committee, that is, those which are not defeated on the floor of either Chamber, remain as live bills and can be reactivated the following year. Whether or not this will remain true as a result of reapportionment of the House is a question yet to be given a legal answer. Should they remain as live bills, MAG will go into the next session of the General Assembly with a major portion of its legislative program waiting for it.

**Re: Letterhead For Each  
Medical Staff**

March 9, 1965

The Editor  
Journal of the Medical Association of Georgia  
938 Peachtree Street, N. E.  
Atlanta, Georgia

Dear Sir:

Does the Medical Staff of any hospital in Georgia have its own letterhead? Do physicians writing on behalf of official medical organizations, particularly those writing at the "grass roots" levels for committees, use a letterhead of that organization, even if typed? I have not known of a "Medical Staff" letterhead in any of the places I've studied and practiced in, including New England, Michigan, New Jersey, Georgia and California.

A particular occasion for a proper letterhead is when "grass roots" workers are writing about business of a medical organization. In many instances these communications are on hospital letterheads and appear to be coming from an administrator's office, yet the contents of the letters are very foreign to the letterhead.

Today I asked the administrator of a local hospital for his views regarding a "Medical Staff" letterhead. He

replied that the trustees of the hospital have their letterhead, he has his letterhead and he felt that it was only right that the Medical Staff have its letterhead. Others with whom I have discussed this topic all feel that this identification would do much to help establish the position of the Medical Staff and help the public understand the position of the physician in relation to organized medicine and organized health services.

Recently I brought this up at the Coweta County Medical Society meeting and we will be initiating a resolution to carry this principle of identification by letterhead through the state and AMA channels, with particular reference and application to Medical Staffs of hospitals. Some Medical Staffs may want to initiate this identification before such a resolution advances through the various channels.

I wonder what the effect would be if government and other planners each received a letter from the Medical Staff of each hospital in Georgia. I do not believe this avenue has been explored.

Sincerely yours,  
Robert M. Webster, M.D.

**EMORY TO SPONSOR  
POSTGRADUATE SEMINAR**

A Postgraduate Seminar titled, "Obstetrical Factors in Child Development," will be presented by the Department of Gynecology and Obstetrics, Emory University School of Medicine on May 17 and 18, 1965. Departmental faculty members are anticipating a capacity registration of 300 for the two day meeting to be conducted at Grady Memorial Hospital.

Guest faculty and program participants will include Dr. George W. Anderson, Associate Professor of Obstetrics, Tufts University; Dr. Virginia Apgar, Director, Division of Congenital Malformations, The National

Foundation March of Dimes; Dr. Josef Warkany, Professor of Research Pediatrics, University of Cincinnati; and Dr. Benjamin Pasamanick, Professor of Psychiatry, Ohio State University.

Persons seeking additional information are invited to write: *Gyn-Ob Postgraduate Education, 69 Butler Street, S.E. Atlanta, Georgia 30303.*

No tuition will be required for persons who attend. However, advance registration is requested. The seminar will be held at Grady Memorial Hospital in Atlanta, Georgia.

# NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

Anderson, Benjamin S., Jr. Active—Polk	211 Merritts Ave. Cedartown, Georgia	McLeod, Wallace N. Active—Fulton	340 Boulevard, N.E. Atlanta, Georgia 30312
Askren, Edward L., III Active—Fulton	3390 Peachtree Road, N.E. Atlanta, Georgia 30326	Nahmias, Andre J. Active—Fulton	69 Butler Street, S.E. Atlanta, Georgia 30303
Bannister, James P. Active—Fulton	490 Peachtree Street, N.E. Atlanta, Georgia 30308	Pollock, Charles E. Active—Wilkes	Washington, Georgia
Berg, George M. Associate—Muscogee	Muscogee Co. Health Dept., Box 2299, Columbus, Georgia	Rigdon, Henry L. Service—Laurens	V. A. Center Dublin, Georgia
Berger, Merton B. Active—Fulton	478 Peachtree Street, N.E. Atlanta, Georgia 30308	Roberts, Stewart R., Jr. Active—Fulton	1421 Peachtree Street, N. E. Atlanta, Georgia 30309
Bland, James W., Jr. DE 2—Fulton	69 Butler Street, S.E. Atlanta, Georgia 30303	Rog, Mieczslaw Service—Laurens	V. A. Center Dublin, Georgia
Bush, Charles K. Active—Fulton	47 Trinity Avenue, S.W. Atlanta, Georgia 30303	Smith, Chandler H. Active—Fulton	300 Boulevard, N.E. Atlanta, Georgia 30312
Cannon, Charles N. Active—Camden-Charlton	Folkston, Georgia	Snyder, Edward D. Active—Cobb	Cherokee Medical Building Smyrna, Georgia
Caplan, J. Louis Service—Fulton	441 W. Peachtree St., N.E. Atlanta, Georgia 30308	Tait, C. Downing, Jr. Active—Fulton	Emory Univ. School of Med. Atlanta, Georgia 30322
Drake, Henry C. Active—Coweta	137 Jackson Street Newnan, Georgia	Turk, Alfred J. Associate—Coweta	170 Spring Street Newnan, Georgia
Egan, Robert L. Active—Fulton	Emory University Clinic Atlanta, Georgia 30322	Turner, Daniel R. Active—Fulton	1073 N. Jamestown Rd., Apt. L Decatur, Georgia
Haraszi, Alexander S. DE 2—Fulton	69 Butler Street, S.E. Atlanta, Georgia 30303	Ward, Mary C. Active—Cobb	Cherokee Medical Building Smyrna, Georgia
Heinz, Edward R. Active—Fulton	Emory Univ. Hosp., Rad. Dept. Atlanta, Georgia 30322	Williams, Malcolm H. Active—Cobb	2404 Marietta-Austell Road Austell, Georgia
Hockett, William J. Active—Fulton	Holy Family Hosp., Sewell & Fairburn Rds., S.W., Atlanta	Woodard, John R. Active—Fulton	Emory University Clinic Atlanta, Georgia 30322
Johnson, James T. Active—Fulton	705 Juniper Street, N.E. Atlanta, Georgia 30308	Yarbrough, James E. Associate—Muscogee	2942 Lynda Lane Columbus, Georgia
Lovell, Martha S. Active—Fulton	1649 Cleveland Ave. East Point, Georgia	Yeager, Otis Wayne Active—South Georgia	316 E. Cowart Avenue Valdosta, Georgia

## THE MEDICAL TYPISTS' COURSE

For the past eight years an experimental program for medical secretaries has been in progress at Augusta Vocational School, a division of the state public school system. The primary purpose of this program has been to find a way that a business teacher can successfully handle this technical specialty in her field.

### All Subjects

The Medical Typists' Course includes all the subjects necessary to turn out a finished product in this field: medical terminology, medical typing, speed typing, dictating machine transcription, and business English, etiquette, and dress. It is possible for an advanced typist to complete this course in a four-month program.

On May 15 an educational forum on "Teaching the Medical Typists' Course" will be held at the Medical College of Georgia. Educators from vocational schools,

large high schools, YWCA's, business schools, colleges, and hospitals will be invited to attend. This forum will be followed up by a one-week teacher-training program in the summer.

Would you like for the Medical Typists' Course to be set up in a school near you? If so, contact the administrator in that school and express an interest in this program to him.

### By Correspondence

Your own secretary may need further training but has no time for the classroom instruction. Her needs will be met, too. The Medical Typists' Course is available by correspondence.

For further information, write P.O. Box 3716, Augusta, or call 738-3033.





## THE CHANGING OF THE GUARD

AS the 111th Annual Session approaches in Augusta, Georgia, there comes a changing of the guard—and that is as it should be. Some of us who have been in the “thick of things” over the past few years, will be introduced to the pasture. The fences will not be too high, nor mended too well—but there’s little likelihood of us breaking out, because after years of hard work, we are perfectly content to let those with stronger backs, more agile minds and younger bodies take over the multiplicity of chores that make up the governing body of the Medical Association of Georgia.

To be elected to any office in the MAG certainly has its rewards. I must truthfully say that I have met some exceptionally delightful people, both professional and lay, that I would never have met under any other circumstances. I can assure all of you, too, that my wife has enjoyed these past years. She has been tremendously pleased, as I have, with all the niceties and refinements that you in the MAG have showered upon us.

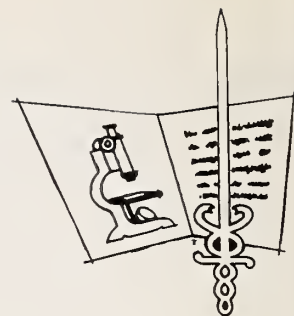
### What It Has Meant

It has been work—sure. It has meant a lot of travelling—certainly. Away from the office a great deal—yes. But you know something—my patients understood it—I have never received a single complaint. And you know something else—I never had a doctor in the city of Atlanta refuse to cover for me when I was away on MAG business—and fail to send the patient back to me. Many times I had not asked them to cover; the patient simply called and stated that I was their regular doctor but was away at a meeting in Chicago, Miami, or somewhere in Georgia—and they took care of things.

Doctors and their wives are like that. They are a grand people. The milk of human kindness flows freely within them. If you do not believe it, then take the next job that MAG offers you and you’ll find out. I’ll be watching you from the pasture.

A handwritten signature in dark ink, reading "J. G. McDaniel". The signature is fluid and cursive.

*J. G. McDaniel, M.D.  
President, Medical Association of Georgia*



## CANCER REGISTRIES

Hans J. Peters, M.D., *Augusta*

THE AMERICAN College of Surgeons established certain minimum standards to which institutions seeking approval for their cancer programs must conform. One of the requirements specifies that a Cancer Registry shall be in operation at that institution.<sup>1</sup>

Cancer or Tumor Registries are repositories of records containing pertinent information on diagnosis, treatment, follow-up and end results of all patients with a diagnosis of cancer who have been admitted either as in- or out-patients to a hospital.

### Of Great Value

It must be apparent that the data collected in such a registry is of great value for everyone concerned with the problem of cancer. This, for instance, might help the individual physician to review the results he obtained in the treatment of his cancer patients concerning specific types of therapy, and nationally might serve for over-all evaluation of specific cancer problems. The data collected in the registries can be used as important adjuncts in the hospital teaching programs.

At the present time there are 26 cancer registries in Georgia of which 19 are active registries. The establishment of the registry system in 1956 in the State of Georgia in large measure is due to the efforts of the staff of the Robert Winship Clinic at Emory University Hospital. Each of these registries is directed by a physician who has a particular interest in the field of neoplasia and who is appointed to this position by the hospital staff. In the smaller hospitals the registries are usually operated in conjunction with the medical record room; in the larger

institutions they might be independent units. The Georgia Division of the American Cancer Society has for many years assisted the registries financially and has supplied the necessary stationery for operation free of charge. At the end of each year the status of each registered patient is reported to a central office and the collected data from all registries in the State of Georgia is then processed by the data-processing division of the State Health Department for statistical analysis.

### Registered Patients

As of December, 1963, 59,136 cancer patients were registered in Georgia. This represented an increase by some 8000 cancer patients from the year 1962. However, this does not reflect the true incidence of cancer in the state; some patients not admitted to a hospital that has a cancer program would not be registered. Of the 59,136—27,285 were treated by surgical means, 13,160 received radiation therapy and 4,239 received combined surgical and radiation therapy. 7,761 received no treatment and the remainder received some other type of therapy. As of 1962, the State registry indicated that for all cancers the survival rate was 36% at the end of three years.

For the secretaries in such registries, educational programs are conducted to keep them informed about the latest developments in cancer control and statistical analysis. In December of 1964, a two-day Workshop was held for Secretaries of Georgia Tumor Registries at the Medical College of Georgia.

### References

1. *Manual for Cancer Programs*. American College of Surgeons, Chicago, Ill., 1961.

*Approved by the Professional Education Committee, Georgia Division, ACS.*

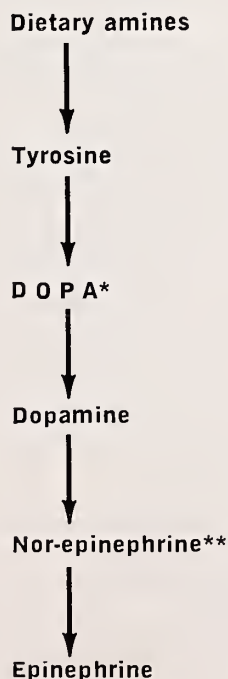
*From the Department of Pathology, Medical College of Georgia.*





THE TWO main sympathetic amines, epinephrine and nor-epinephrine, are often referred to together as CATECHOLAMINES. (Catechol refers to the 1-2 dihydrobenzene ring.) The stimulus for the increase in knowledge of catecholamine metabolism has been the discovery of many new drugs which lower the blood pressure in hypertensives. Nearly all these drugs with marked antihypertensive effects have been shown also to affect either the tissue levels or the metabolism of nor-epinephrine or other catecholamines. Whether these two effects are casually related is not certain as yet, and whether *Essential Hypertensives* have a primary defect in catecholamine metabolism is controversial. Most scientists feel that the difference in excretion patterns of catecholamines and their metabolites seen in essential hypertensives are a result of the elevated blood pressure rather than the cause and may be due to reduced sympathetic activity when the blood pressure is maintained by some other mechanism. What goes on at nerve endings and motor end plates regarding production, release, storage, and inactivation of catecholamines in humans is as yet unproven. There may be marked differences in the metabolism of exogenous catecholamines compared with endogenous catecholamines, and most of the work has been done on radioactively tagged exogenously administered nor-epinephrine.

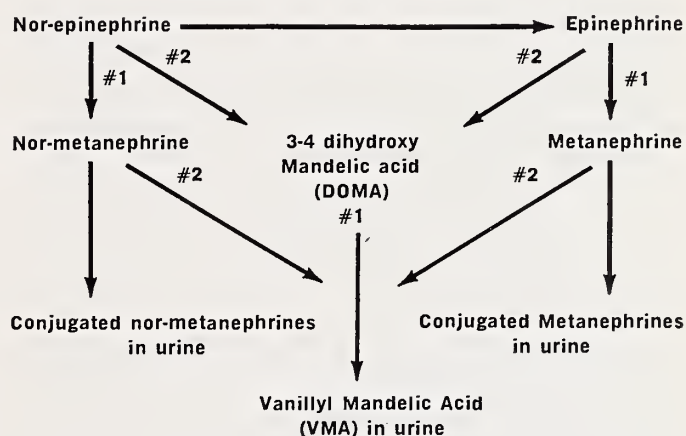
What we know so far may be illustrated diagrammatically as follows:



## CATECHOLAMINE METABOLISM

Joseph A. Wilber, M.D., *Atlanta*

Then pathways become more complicated.



The enzyme "Catechol-O-Methyl Transferase" (COMT) is involved at the points labeled #1. "Monamine Oxidase" (MAO) acts at points labeled #2. (Eutonyl® is a MAO inhibitor.) COMT seems to be the enzyme involved in the major route for circulatory amines. MAO may be the major enzyme involved at nerve endings.

It is too early to explain the action of our anti-hypertensive drugs by their effects in inhibiting the above enzymes—in fact, other more powerful inhibitors have no blood pressure lowering effect. But it is most likely that as chemical techniques are refined and mechanisms of neurohumeral transmission are clarified, great therapeutic advances will be made not only in hypertensive disease but in all areas of human disease.

*Georgia Department of Public Health*

\*Dopa decarboxylase is the enzyme involved here and this is inhibited by alpha-methyl-dopa (Aldomet®).

\*\*The storage and/or release of nor-epinephrine at nerve endings is affected by both reserpine and guanethidine (Ismelin®).

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.



## MORAL TURPITUDE

John L. Moore, Jr., *Atlanta*

**W**HAT is "moral turpitude"? The commission of a crime involving moral turpitude is one of the reasons for the revoking of the license to practice of a medical doctor in most states. An interesting case arose recently in Wisconsin on this point.

A physician was indicted and convicted of four counts of attempting to evade and defeat a large part of his federal income tax by filing false and fraudulent returns. He was sentenced to imprisonment of one year and fined \$15,000. He was also convicted of having corruptly endeavored to influence an officer of a court of the United States and to obstruct the administration of justice in such court. For this crime, he was sentenced to imprisonment for five years and fined \$5,000.

While the physician was imprisoned, proceedings were brought by the district attorney in the state court to revoke his license to practice medicine, charging that the physician had been guilty of unprofessional conduct.

The trial court decided to revoke the prisoner's license to practice medicine entirely rather than to use a two years' suspension. The physician appealed to the Supreme Court of Wisconsin which affirmed the revocation of the license. The Supreme Court of Wisconsin said that it approved the language used by the trial judge:

"... The defendant's moral turpitude evidenced in one aspect of his relationship to society was thus reaffirmed in connection with another relationship of his to society. Upon what basis can the Court conclude that this perfidy has not permeated his entire character and will not extend to the physician-patient relationship?"

Both the trial court and the Supreme Court made it clear that it thought the physician's license could and should have been revoked if he had been guilty only of filing false and fraudulent income tax returns. However, the courts were of the opinion that his attempts to bribe a court officer buttressed the result.

It is interesting to note that the same result as to the filing of false and fraudulent income tax returns would probably not be obtained in Georgia. In 1957, the reasons for revoking licenses to practice medicine were substantially rewritten. The second reason for revocation of a license reads as follows:

"The commission of a crime involving moral turpitude; the conviction of a crime involving moral turpitude shall be conclusive evidence of the commission of such crime and a fine or sentence based on a plea of *nolo contendere* shall be equivalent to conviction. For the purpose of this section a conviction, plea of guilty or a plea of *nolo contendere* to a charge or indictment by either Federal or State Governments for income tax evasions shall not be considered a crime involving moral turpitude."

It is interesting that the Georgia General Assembly, in enacting the quoted section, made a legislative finding that conviction of income tax evasion does not involve moral turpitude. This, of course, runs entirely contrary to the reasoning of the Supreme Court of Wisconsin.

In this day of increasing governmental interest in social and economic affairs, it is interesting to ruminate on the possibilities.

It is possible that a medical doctor could be an officer of a corporation guilty of setting industry prices contrary to anti-trust laws. If such doctor were imprisoned for a month, like the Westinghouse officials, he might lose his license to practice. Similarly, if a medical doctor were concerned with the sale of securities which violated the federal securities laws, he might be subjected to prosecution and to revocation of his license. To the writer, however, these examples seem somehow less serious than the intentional filing of fraudulent income tax returns.\*

\*The case discussed in the foregoing article is *Wisconsin v. Margoles*, 21 Wis. 2d 224, 124 N.W. 2d 37 (1963).

Prepared at the request of The Medical Association of Georgia, Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.



# HOSPITALS GET 28 CENTS OF HEALTH DOLLAR

Hospitals received the largest share of every health dollar spent by Americans in 1963, according to Department of Commerce figures on personal expenditures.

Twenty-eight cents of every health dollar went to hospitals, 25 cents went to doctors, 18 cents was spent on drugs, 10 cents was paid to dentists, 8 cents went for health care, 6 cents went for the purchase of appliances, and 5 cents was spent on all other services.

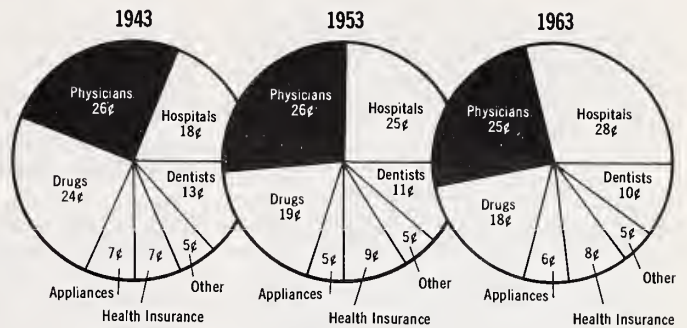
The doctors' share of payments for health care was up one per cent from 1962, but was down one per cent from the share received 10 years earlier.

An analysis of the 1963 statistics by the American Medical Association's Department of Medical Economics shows the nation's consumers spent \$23.6 billion for health care in 1963, including \$6.6 billion for hospital charges, \$4.3 billion for drugs, and \$5.9 billion for physicians' services.

Americans spent a total of \$375 billion for their personal needs in 1963. About 6.3 per cent of this went for health care.

Other consumer expenditures in 1963 included food, \$76 billion (20.3 per cent of the total); clothing, accessories and jewelry, \$37.1 billion (9.9%); housing, \$48.9 billion (13%); household operation, \$52.4 billion (14%); transportation, \$47.2 billion (12.6%); recreation, \$22.7 billion (6%); private education and research, \$5.7 billion (1.5%).

DISTRIBUTION OF THE "HEALTH CARE DOLLAR"  
For Years 1943, 1953, and 1963



SOURCE: U. S. Dept. of Commerce  
AMA News Graphichart

Tobacco, \$8.1 billion (2.2%); liquor, \$11 billion (3%); foreign travel and remittances, \$3.5 billion (0.9%); religious and welfare activities, \$5.4 billion (1.4%); personal business, \$24.9 billion (6.6%); personal care, \$6.5 billion (1.7%); and all other, \$1.8 billion (0.5%).

Of the total personal consumption expenditures in 1963, \$167.5 billion was spent on nondurable commodities, \$52 billion was spent for durable commodities, and \$155.3 billion was spent for services, including the \$5.9 billion paid for physicians' services.

## SUMMARY OF RECENT MAG COUNCIL AND EXECUTIVE COMMITTEE ACTIONS

(The full minutes from which these summaries have been abstracted are available to any MAG member upon request to the Journal.)

### Executive Committee / February 14, 1965

Correction of minutes of January 29, 1965, Executive Committee Meeting: In the "State Marriage Laws Legislation" section, a correction should be made in item (3), which would make that read: "(3) that parental consent be obtained for persons under age 19." With this correction made the minutes were approved as read.

Received for information: MAG attorney's fee for MAG tax case; appropriation has been set aside.

Appointment: J. W. Chambers, LaGrange as Chairman of the MAG Delegation to the AMA House of Delegates meeting in 1965.

Treasurer's Report, read by Dr. Atwater, approved as presented.

Voted to approve the payment of increase in hospital room allowance, which would eliminate the \$50 deductible, in the Blue Cross-Blue Shield room allowance for MAG employees.

Recommended: that an investigation be made of the costs involved in paying for catastrophic insurance for the MAG Executive Staff with decision to be made by council.

Dr. Atwater was asked to present at the March Council Meeting the proposed policy for reimbursement of members' expenses in conduct of MAG business.

Ad Hoc Nursing Home Study Committee: Dr. Charles Cowart, LaGrange, will be contacted to hold the committee together for whatever future action will be necessary, as its initial purpose has been accomplished.

Received for information: Report on AMA House of Delegates Meeting February 6-7, 1965. Dr. McDaniel reported that the AMA House of Delegates gave approval and support to the AMA Eldercare Program and the Herlong-Curtis Eldercare bill (H.R. 3727).

Legislative Report: Mr. Moffett reported on state legislation as follows: Kerr-Mills implementation; Anti-Child Abuse; Osteopathy, a person trained in the field of sanitary engineering; Marriage Laws; Postmortem Act; and Fluoridation. The Executive Committee took no action on any of the above except the changes in the postmortem act, which they opposed.

Clarification of Action on Oral Contraceptives: Mr. Krueger reviewed the action taken on the dispensing of oral contraceptives at the January 29, 1965, Executive Committee meeting. There had been some misunderstanding by the State Department of Health on the action. The MAG Maternal and Infant Welfare Committee was present during this discussion and after explanation the action taken by the Executive Committee in January was reaffirmed. However, it was suggested that there should be some clarification with the pharmacists regarding the information submitted by the State Department of Health. In order to accomplish this, a meeting of the President of the Georgia Pharmaceutical Association, the MAG Maternal and Infant Welfare Committee, and the MAG members of the Interprofessional Council is to be arranged. On motion (Andrews-Mauldin) it was voted to approve the Family Planning Policies and Plan of Operation of the State Department of Health if no major changes are made in them by representatives of the Georgia Pharmaceutical Association and in the MAG Maternal and Infant Welfare Committee at the meeting.

Voted to empower Dr. McDaniel to make nominations for State Advisory Committee on Alcoholism.

Voted to reappoint Dr. John Godwin to Radiation Control Council.

Appointment of Advisory Committee to Radiation Control Council: Recommended that MAG appoint a committee to act in an advisory capacity to Radiation Control Council. Dr. Mauldin was asked to contact the President of the Georgia Radiological Society regarding the possibility of their committee, composed of MAG members, functioning also as an advisory committee of MAG with liaison with the MAG Executive Committee.

AMA "Today's Health" Gift: Two original drawings have been presented to MAG by "Today's Health" because they were used in the John Wesley story which appeared in the December, 1964 issue. On motion it was voted to present the color print to the Georgia Medical Society and retain the black and white print for the MAG Headquarters.

Dr. Atwater reported that he had attended an AMA Conference on Health Care of the Aged held in Chicago recently.



## ABSTRACTS BY GEORGIA AUTHORS

Clay, James R., M.D., and Robert G. Rossing, M.D., Ph.D., Athens General Hospital, Athens, Georgia, "Histopathology of Exposure to Phosgene," Arch. Path. 78:544-551(Nov)64.

Adult dogs were exposed to phosgene (COCl<sub>2</sub>) in an attempt to produce pulmonary emphysema experimentally. The exposure rate was one to three times a week with a dosage of 24 to 40 parts per million of phosgene in air. The dogs that were sacrificed after one to ten exposures showed extensive inflammatory lesions of the terminal and respiratory bronchioles. As the number of exposures increased, there was progressive bronchiolitis with distortion and, in some cases, obliteration of the bronchioles and respiratory bronchioles. In the animals exposed over the longest period of time, the changes closely resembled human centrolobular emphysema. These changes were demonstrated both by routine histologic technics and by micro-sections. These findings are briefly related to

several concepts of the pathogenesis of emphysema.

Messer, Alfred A., M.D., Emory University, Atlanta 22, Georgia, "Family Treatment of a School Phobic Child," Arch. Gen. Psychol. 11:548-555(Nov) 64.

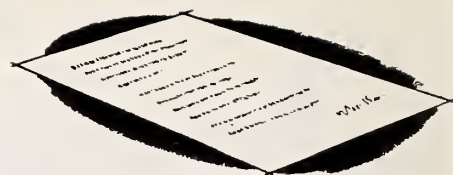
A phobic child and his family were studied for two years. The proposition in this paper is that the child's phobia is a symbolic public expression of breakdown of equilibrium in the family. The pathologic interaction of the family members prior to the onset of the phobia is described. This interaction, although interfering with creative growth or growth in self esteem in each individual member, did serve the defensive purpose of keeping anxiety within tolerable limits and allowing the family to keep functioning as a unit. The events that led to a disruption of the family equilibrium are reviewed. It was reasoned that if the equilibrium could be restored, the phobic symptom should disappear. Treatment involved seeing the entire family simultaneously.

A shift in family equilibrium as well as relief of symptoms was affected.

Anabtawi, Isam N., M.D., and Robert G. Ellison, M.D., Medical College of Georgia, Augusta, Georgia, "Maldevelopment of the Pulmonary Veins and Pulmonary Arteriovenous Aneurysms," Am. Surg. 30:770-773(Nov)64.

The authors describe an unusual case of centrally located pulmonary arteriovenous aneurysm. The neck of the aneurysm with the atrium was approximately 6 centimeters in diameter. The embryology of the pulmonary venous system is discussed in relation to the anomaly. The described case suggests malformation of the primitive venous trunk posterior to the heart prior to its absorption into the left atrium.

Parrish, Robert A., M.S., M.D.; J. K. Tippens, B.S.; M.M. Pulliam, B.S.; and William H. Moretz, M.D., Medical College of Georgia, Augusta, Georgia, "Formalized Skin Substitute for Grafting Burns: A Preliminary Report," Am. Surg. 30:793-798(Nov)64.



the most widely  
prescribed  
peripheral  
vasodilator...

**ARLIDIN**

brand of

**NYLIDRIN HCl**

increases

blood flow...



### IN CEREBROVASCULAR INSUFFICIENCY

leading to such symptoms as  
mental confusion, diplopia,  
vertigo and lightheadedness.



### IN PERIPHERAL VASCULAR DISEASES

where ischemia causes  
pain, spasm, ache,  
intermittent claudication; also  
coldness, numbness or ulceration  
of extremities.



Heterogenous (dog) skin treated with formalin was used as a full-thickness cover over surgically created skin voids on the rat's back. The formalized skin was retained by the host for a evidence of rejection or infection. This material remained pliable and failed to period of six weeks without any gross produce the expected intense inflammatory reaction. Upon removal of the skin substitute, the recipient site readily accepts a split-thickness autograft. It should be emphasized that this is a preliminary report and the applicability of this technique to other hosts is not known at this time.

**Parrish, R. A., M.D.; M. M. Pulliam, B.S.; J. K. Tipples, B.S.; and W. H. Moretz, M.D., Medical College of Georgia, Augusta, Georgia, "Synthetic Resin Adhesive for Placement of Skin Grafts," Am Surg. 30:753-755(Nov)64.**

Eastman's 910-monomer was used for the placement of 30 skin grafts on five mongrel dogs. Sloughing of the skin occurred wherever this glue was applied, whereas 15 control grafts remained viable, the environment being similar for all except for the addition of glue in the experimental group. The use of this monomer is limited in its effectiveness for skin grafting probably because it prevents plasma flow and the development of blood vessels between the graft and graft bed. We would not recommend the clinical use of this ma-

terial in its present form based on these experimental observations.

**Parrish, Robert A., Jr., M.D., and Harry C. Sherman, M.D., Medical College of Georgia, Augusta, Georgia, "The Surgical Significance of Splenic Abscess," Am. Surg. 30:712-716(Nov) 64.**

Most abscesses of the spleen occur as only a part of a generalized process associated with severe septicemia in which many abscesses are scattered throughout the body. These are seldom surgically significant. Less frequent is the patient with an isolated infection in the spleen. Death may result in this form of splenic abscess unless surgical treatment is performed. Two patients with this isolated form of splenic infection are reported and the clinical problems encountered with diagnosis and treatment are discussed. Although simple drainage may suffice in some, splenectomy, whenever feasible, is preferred for primary splenic abscesses.

**Issacs, James P., M.D.; Walter L. Bloom, M.D.; John C. Lamb, B.S.; James L. Burson, B.S., 1968 Peachtree Road, N.W., Atlanta 9, Georgia, "A Simple New Method for Producing Selective Coronary Arterial Thrombosis in the Dog," Surgery 56:1151-1156 (Dec)64.**

Neither new nor standard measures which are employed in the therapy of

coronary arterial disease can be adequately tested experimentally, because we have had no satisfactory experimental animal preparation with which to work. The role of anticoagulants, vasoactive agents, oxygen, digitalis, dextran, mechanical circulatory assistance, etc., require more systematic investigation. It is for this reason that a simple new method has been developed in the laboratory which consists of implanting a small platinum electrode about the vessel so that an electrical current can be employed to produce coronary arterial thrombosis.

A direct electrical current may be applied across any vessel on the surface of the heart, artery, or vein, in order to produce thrombosis of that vessel. Passing a current through a coronary blood vessel does not negate the recording of the electrocardiogram. The further development of this method has made it possible to produce coronary thrombosis in a normal, closed-chest, unrestricted, unanesthetized dog or other animal while recording the electrocardiogram by ultra-high frequency equipment. The initiation of intravascular thrombosis has been demonstrated to be voltage dependent.

**Martin, J. D., Jr., M.D.; W. Earl Bobo, M.D.; and H. Harlan Stone, M.D., Emory University Hospital, Atlanta 22, Georgia, "The Management of Inguinal Hernia in the Elderly Patient," Geriatrics 19:870-874(Dec)64.**



## IN CIRCULATORY DISORDERS OF THE INNER EAR

where decreased blood flow results in hearing loss (sudden onset), tinnitus, or vertigo.

# ARLIDIN<sup>®</sup>

brand of

## NYLIDRIN HCl

decreases resistance in arteries and arterioles in skeletal muscle, in the brain, and possibly in the eye and inner ear • increases cardiac output (minute stroke volume) • maintains mean arterial blood pressure • enhances blood flow in ischemic tissues • well tolerated, with rapid and sustained response • economical

**Dosage:** ½ to 1 tablet three or four times a day is the usual effective dosage; increased, if necessary, to 2 tablets three or four times a day.

**Side Effect:** Occasional palpitation. **Precautions:** Use with caution in the presence of a recent myocardial lesion, paroxysmal tachycardia, severe angina pectoris and thyrotoxicosis. **Contraindication:** Acute myocardial infarction. Consult product brochure.

**u. s. vitamin & pharmaceutical corp.**

800 Second Ave., New York, N.Y. 10017



## IN CIRCULATORY DISORDERS OF THE EYE

in which vasospasm and impaired circulation are factors.

Available in 6 mg. scored tablets, and 5 mg. per cc. parenteral solution.





The incidence of inguinal hernia in the general male population has definitely been shown to increase with advancing age. The prevalence in the age group of 70 years and over varies between 10% and 20%. With the growth of the elderly population group, there is likewise a true increase in the incidence of inguinal hernia. Therefore, it is to be expected that more and more elderly patients will present themselves for treatment of this condition.

There are three important reasons for elective herniorrhaphy in the elderly patient: (a) to alleviate inconvenience and discomfort; (b) to avoid emergency surgical procedures with their increased mortality and morbidity; and (c) to allow more time for thorough evaluation of the patient in addition to the corrective measures which are so important to these individuals.

Elective herniorrhaphy in the elderly patient can be performed with minimal risk to the patient and with assurance of a low recurrence rate. Attention to the minute details is essential. These incorporate careful preoperative evaluation and preparation. Rigid adherence to the basic surgical principles is mandatory for successful repair with a minimum of morbidity. The selection and choice of anesthesia is important in these patients. For certain individuals local anesthesia may frequently be the ideal method.

**Huguley, Charles M., Jr., M.D.; William R. Vogler, M.D.; James W. Lea, M.D.; Charles C. Corley, Jr., M.D.; and Michael E. Lowery, M.D., Emory University Hospital, Atlanta 22, Georgia "Acute Leukemia Treated with Divided Doses of Methotrexate," Arch. Int. Med. 115:23-28(Jan)65.**

Twenty-four adults with acute leukemia were treated with divided, daily oral doses of methotrexate. The dose varied from 1.25 mg. to 3.75 mg. every six hours for a five-day period. This was repeated at intervals of 10-14 days. Toxicity was often severe characterized by stomatitis, nausea, gastrointestinal hemorrhage, and severe marrow depression and usually occurred within 2-5 days following treatment. Recovery from toxic effects was rapid. Definite improvement was seen in 46% of patients and complete remissions defined, as no evidence of disease occurred in 33% of patients. Remissions were delayed in some patients until after three courses of methotrexate. Those patients living long enough to receive three courses of methotrexate had a complete remission rate of 47%. Duration of remissions averaged 98.5 days. The divided, daily dose schedule proved to be an effective method of treating patients with acute leukemia.

**Yeh, Thomas J., M.D.; David P. Hall, M.D., and Robert G. Ellison, M.D., Medical College of Georgia, Augusta, Georgia, "Surgical Treatment of Aortic Valve Perforation Due to Bacterial En-**

**docarditis," Am. Surg. v0:766-769 (Nov)64.**

Bacterial endocarditis, a uniformly fatal disease prior to 1939, has been bacteriologically curable in 75% of cases with antibiotic therapy. Nevertheless, a significant number of patients surviving infection die from congestive heart failure from structural damage to the valves. The prognosis is particularly grave if the aortic valve is involved.

Six cases of aortic valve rupture or perforation due to bacterial endocarditis treated surgically at the Medical College of Georgia were presented. Characteristic symptoms were sudden development or worsening during the course of bacterial endocarditis of an aortic diastolic murmur with peripheral signs of aortic insufficiency and congestive heart failure. All patients were operated upon after stringent antibacterial and anticongestive management. Satisfactory repair was accomplished in all cases, two succumbing postoperatively from wound infection and hemorrhage. The remaining four are well or greatly improved up to 21 months postoperatively.

**Wray, Charles W., M.D.; Charles E. Stark, Jr., M.D.; Edwin L. Brackney, M.D.; and William A. Moretz, Medical College of Georgia, Augusta, Georgia, "Surgical Problems in Amebiasis," Am. Surg. 30:780-785(Nov)64.**

Amebiasis is a protozoan infection occurring in ten per cent of our population. While treatment is primarily medical, surgical complications develop in ten per cent of those hospitalized. These are liver abscess, pleural or pulmonary complications, amebic ulcers of the colon with perforation or bleeding, amebic granulomas and metastatic abscesses and postoperative problems associated with amebic appendicitis.

From 1956 until 1965 there were 41 proven cases of amebiasis treated in the Eugene Talmadge Memorial Hospital. Twenty-four patients with amebic colitis recovered uneventfully. Among the remaining 17 patients there were 15 amebic liver abscesses; three hepatobronchial fistulae and an empyema followed in four of these. One patient had amebic hepatitis that did not lead to abscess. One patient had amebic colitis, liver abscess and cutaneous tuberculosis. Two patients had perforations of amebic abscesses of the colon, one died. One two month old had amebic meningo encephalitis. The three deaths occurred in cases that were not diagnosed until autopsy.

A case is reported in detail to illustrate the treacherous and complex nature of the disease.

The diagnosis and treatment of the various complications are discussed in detail.

Antamebic therapy is necessary for successful treatment of these complications even with the best of surgical techniques. Even appendectomy can

lead to a catastrophe in the face of amebiasis.

**Humphries, Arthur L., Jr., M.D.; Rufus Russell; James Gregory; Robert H. Carter, M.D.; and William H. Moretz, Medical College of Georgia, Augusta, Georgia, "Hypothermic Perfusion of the Canine Kidney for 48 Hours Followed by Reimplantation," Am. Surg. 30:748-752(Nov)64.**

Many human cadaver kidneys have been transplanted; most have had to be immersed in, or infused with, cold solutions and then rushed to the hastily prepared recipient. If kidneys could be protected better against ischemia, they could be transplanted more deliberately into more adequately prepared recipients.

Seven kidneys were perfused for 24 hours under 45 mm. Hg pressure with diluted homologous blood at 10° C. and reimplanted (contralateral kidney excised immediately). Four still maintain health three to five months later.

Seven kidneys were stored with a perfusate of different temperature, pressure, or composition. Several yielded interesting information, but none still function.

Seven kidneys were perfused with diluted autologous blood for 48 hours (contralateral kidney excised two weeks later). Four still maintain healthy three to eight weeks after contralateral kidney excision.

**Rhode, C. Martin, M.D., and W. D. Jennings, Jr., M.D., Medical College of Georgia, Augusta, Georgia, "Retroperitoneal Retrofascial Space Infections," Am. Surg. 30:799-810(Nov)64.**

Retrofascial space infections manifest themselves in a variety of ways. The specific anatomic features influence the onset and course of these infections.

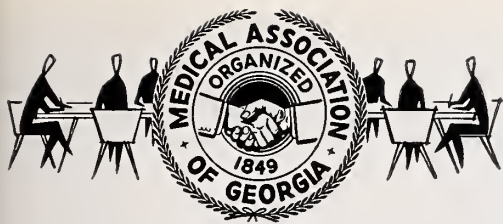
These spaces are deep, lying on the posterior abdominal wall. Each space contains muscle and nerve. They are covered with tough, resistive muscle fascial. The fascial attachments create three spaces.

The characteristics of retrofascial space abscesses are: pus is confined early, not free; these infections are capricious—they are mainly pyogenic but a few are tuberculous in origin; a high index of suspicion is required in dealing with these cases; pain is of a referred nature usually, not local.

Retrofascial space infections may remain localized and resolve or enlarge and form an abscess and spread. The resistive fascia initially confines the pus to the specific retrofascial space. The pus is channeled to remote superficial weak areas as the abscess enlarges. The psoas retrofascial space is a direct channel from the mediastinum to the thigh. Pus in the quadratus retrofascial space points to the lumbodorsal Petit's triangle. Pus in the iliopsoas retrofascial space points to the inguinal ring area or thigh.

The psoas sign was positive in only two of our cases; it was negative in 11 cases.





# THE ASSOCIATION

## DEATHS

DOUGLAS L. HEAD, SR., 67, of Zebulon, died at Upson County Hospital, Thomasville, February 3, 1965.

Dr. Head was a native of Pike County, and had resided there all of his life. He was a graduate of Emory University Medical College, and served his internship at Georgia Baptist Hospital in Atlanta. He began his practice in Concord, Georgia, in 1920, and moved his practice later to Zebulon in 1922. He had practiced there since 1922. In the 1930's he established the Zebulon Clinic, and practiced at the clinic until ill health limited his practice.

He had served for 44 years as a physician.

Survivors include, his wife, Mrs. Adele Smith Head of Zebulon; one daughter, Mrs. W. J. Richardson of Savannah; one son, Dr. D. L. Head, Jr., of Thomaston; one sister, Miss Lutie Head of Zebulon; one brother, Mr. Horace Head of Anniston, Ala., five grandchildren also survive.

ELIZABETH PEABODY, Georgia pediatrician who organized the first child health clinic in Iraq, died February 18, 1965, in the U.S. Public Health Hospital, Baltimore, after a long illness.

The 59-year-old doctor was a former director of the regional office of the Children's Bureau of the U.S. Public Health Service in Atlanta. She continued living in Atlanta after her retirement in 1964.

She was graduated from Randolph-Macon Woman's College and the Johns Hopkins University School of Medicine.

After serving for a time on the hospital staff there she practiced pediatrics in Annapolis, Md. She did her work in Iraq under the Four-Point Program, setting up a hospital in Iraq. She also worked in Greece and in France.

Active in Girl Scout work, Dr. Peabody was the first Georgia winner of a Golden Eaglet. Her portrait hangs in the Juliett Lowe House in Savannah.

Dr. Peabody was a member of the First Presbyterian Church.

Survivors are a daughter, Mrs. Emily T. White of Atlanta; sons, Lawrence D. Trevett of San Francisco, Calif., and John Peabody Trevett of Bristol, Md., and a granddaughter.

HELEN SHARPLEY, Savannah, died February 19, 1965, at Memorial Hospital, Savannah.

A specialist in obstetrics and gynecology and in diseases of women and children, Dr. Sharpley received her medical degree from the University of Georgia in 1945.

She was one of the founders of the Armstrong Alumni Association and had received several awards from the college.

In 1954, she was the first recipient of the Armstrong

College Gold A award for outstanding service to the school. She was named president of the Armstrong Alumni Association in 1951 and was appointed to the Armstrong College Commission by the city in 1953.

Surviving are an adopted daughter, Miss Ann Lynn Sharpley; her mother, Mrs. Louise Sharpley; a sister, Mrs. Marian Cowart; two brothers, Dr. Hiram F. Sharpley, Jr. and Dr. John G. Sharpley, several nieces and nephews.

EGBERT M. TOWNSEND, 78, a retired Captain in the U.S. Public Health Service, died at his residence February 19, 1965.

He was a Shriner, a member of the Knight Templars, Tillman Lodge, F&AM, and the Ringgold Eastern Star.

Dr. Townsend was also a member of the board of trustees of Hutcheson Memorial Hospital, the Walker-Dade-Catoosa County Medical Society and the Catoosa Board of Education. Active in the Boynton Baptist Church, he was a teacher of the men's adult class and on the board of deacons. In addition, he was a member of the Boynton Lions Club.

He is survived by his wife, Mrs. Ocie Johnson Townsend, Ringgold; daughter, Mrs. Mary Ann Michael, Atlanta; son, John W. Townsend, Mobile, Ala., and three grandchildren.

## SOCIETIES

Morgan Smith, Fitzgerald, was recently elected President of the BEN HILL-IRWIN COUNTY MEDICAL SOCIETY. He succeeded W. C. Sams, Jr. of Ocilla. Ralph Roberts was elected Secretary-Treasurer, and Roy Johnson, Jr., and Ralph Roberts were appointed Delegates to MAG. Both are from Fitzgerald.

James E. Anthony has been elected President of the DEKALB COUNTY MEDICAL SOCIETY. Other officers elected include Harper H. Butterworth, Jr., Vice-President; Catherine E. Foster, Secretary-Treasurer; Frank E. Morgan, Corresponding Secretary; and Luther M. Vinton, President-Elect.

SUMTER COUNTY MEDICAL SOCIETY has elected T. Schley Gatewood as President, succeeding Frank Castellow. R. A. Collins was elected to the MAG House of Delegates, Fred Thompson was re-elected as Vice-President and Harvey Simpson will continue to serve as Secretary-Treasurer. All are from Americus.

TRI-COUNTY MEDICAL SOCIETY recently elected new officers. They are Gordon Hixon, Chattanooga, Secretary-Treasurer; John Ellis, Rossville, President; and M. K. Cureton, LaFayette, Vice President.

## PERSONALS

The following Georgia physicians have recently been certified as Diplomates of the American Board of Pathology: BOBBY LEE CALDWELL, ROBERT A. FARRELL, and DOROTHY T. GRIFFITH, Atlanta; JOSEPH F. KRAFKA, LaGrange; JAMES L. STITH, Macon; and F. NORMAN BOWLES, JR., Marietta.

### First District

C. E. BOHLER of Brooklet spoke to the Metter Kiwanis Club February 2, 1965, concerning the medicare bill.

### Second District

JAMES KIRKPATRICK, Tifton, was the guest speaker at the January meeting of the Allied Medical Career Club at Tift County High School. He explained how diagnoses are made and the various treatment of diseases of the arteries and veins.

Donalsonville physician, H. B. JENKINS, spoke in February to the Donalsonville Lion's Club. Dr. Jenkins' topic was the medicare bill now pending in the U.S. Congress.

### Third District

LUTHER WOLFF, Columbus surgeon, was guest speaker at the luncheon meeting January 27, of the St. Francis Hospital Auxiliary. His subject was medicare.

### Fifth District

HARRY A. FOSTER has returned to Lithonia after an absence of four years to begin the practice of pediatrics and pediatric cardiology with A. H. HUNT, 7494 Covington Highway. Dr. Foster became a Fellow of the American Academy of Pediatrics in November, 1964.

J. FRANK WALKER, Atlanta, was elected a Chancellor of the American College of Radiology at the annual meeting in Philadelphia, February 12.

WALTER L. BLOOM, Atlanta, spoke in February to the Northside Kiwanis Club. His subject concerned the prevention of heart attacks. Dr. Bloom is Director of Medical Education and Research at Piedmont Hospital, Atlanta.

ALFRED A. MESSER, Atlanta, attended the American Psychiatric Association Research Conference on Family Treatment in Galveston, Texas, February 25-28. He was formal discussant for three papers on marriage and family treatment.

Installed as Fellows of the American College of Obstetricians and Gynecologists at its annual meeting held April 4-8, in San Francisco were JACOB A. SPANIER, Atlanta, and HUGO SANCHEZ MORENO, East Point.

CHENEY C. SIGMAN, JR., Atlanta, recently attended the Twenty-first Annual Meeting of The American Academy of Allergy at Bal Harbour, Florida, and a Postgraduate Course on "Basic and Applied Dermatology" immediately preceding the Academy meeting. He completed a U.S. Public Health Service course entitled "Sampling and Identification of Aero-Allergens" given after the Academy meeting. Dr. Sigman serves on the Pollen and Mold Committee of the Research Council of The American Academy of Allergy.

### Seventh District

New officers of the medical staff of John L. Hutcheson Memorial Tri-County Hospital, Ft. Oglethorpe, are JEROME P. SIMS, Ft. Oglethorpe, Chief of Staff; EDWARD G. JOHNSON, Chattanooga, Vice Chief of Staff; and JOHN C. ELLIS, Rossville, Secretary.

### Ninth District

JAMES B. WILBANKS, Clarksville, was one of 60 physicians from the Southeast who participated the last week in January in a postgraduate symposium on Electrocardiology at the Medical College of Georgia, Augusta.

### Tenth District

The Medical College of Georgia, Augusta, has announced the appointment of GORDON M. FOLGER, JR. as Assistant Professor of Pediatrics.

Dr. Folger is a native of Ohio. He attended the University of Florida, and received his medical degree from Tulane University. Following a year of internship at Temple University Hospital in Philadelphia, he took his residency training in pediatrics at St. Christopher Hospital for Children, also in Philadelphia. Dr. Folger recently completed a three-year Fellowship in pediatric cardiology at Johns Hopkins Hospital, Baltimore.

## THE DIFFICULT BIRTH OF A NEW DRUG

Before enactment of the Drug Amendments of 1962, five to six years were required on the average to place a truly new drug on the market. Now, if the current law and regulations stand, or if there are lacking the right interpretation and regulatory practice, it may well take a decade or longer. The real impact of the 1962 amendments, then, may be felt in the forthcoming decade, not this year or next. Thus, the tempo of discovery and development of new drugs could be set back for years. Other products, too, could be delayed

until the log jam breaks. There are some who have expressed the hope that no one dies or suffers unnecessarily during this period for lack of a drug that is not there but could have been if the channels of discovery and distribution were not riddled with hindering laws, regulations, or misunderstanding. — Austin Smith, M.D., President, Pharmaceutical Manufacturers Association in *Southern Medical Bulletin*, December, 1963.



Medical Association of Georgia Journal

**JOURNAL  
OF THE MEDICAL  
ASSOCIATION**

MAY / 1965

Georgia

LIBRARY MEDICAL CENTER LIBRARY

JUN 4 1965

San Francisco 94122

"A"

Lines



"B" Lines

**Interstitial Edema in  
Early Congestive Failure**

**See page 159**





Silver Maple  
(*Acer saccharinum*)

## Distress for Allergic Patients

Kapseals®

**Benadryl®**  
(diphenhydramine hydrochloride)

PARKE-DAVIS

## To Combat Symptoms of Tree-Pollen Allergy

This time-tested agent provides two actions that effectively combat symptoms of seasonal allergy: *Antihistaminic*—relieves sneezing, nasal congestion, itching, and lacrimation. *Antispasmodic*—relieves bronchial and gastrointestinal spasm. **Precautions:** Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers, if used with BENADRYL, should be prescribed with caution because of possible additive effect. Diphenhydramine has an

atropine-like action which should be considered when prescribing BENADRYL. **Side Effects:** Side reactions, commonly associated with antihistaminic therapy and generally mild, may affect the nervous, gastrointestinal, and cardiovascular systems. Most frequent reactions are drowsiness, dizziness, dryness of the mouth, nausea, and nervousness. BENADRYL is available in several forms including Kapseals containing 50 mg. The pink capsule with the white band is a trademark of Parke, Davis & Company. 72-555

**PARKE-DAVIS**

PARKE, DAVIS & COMPANY, Detroit, Michigan 48202





**JOURNAL**  
OF THE MEDICAL  
ASSOCIATION *Georgia*

**Contents**

**EDITOR**

Edgar Woody, Jr., M.D.

**MANAGING EDITOR**

Merrilie M. Davis

**STAFF**

Thelma V. Franklin, *Business*

**CONTRIBUTING EDITORS**

Herbert S. Alden, M.D.; Preston D. Ellington, M.D.; Thomas Findley, M.D.; J. Willis Hurst, M.D.; Charles S. Jones, M.D.; Arthur M. Knight, Jr., M.D.; Arthur J. Merrill, M.D.; Lester Rumble, Jr., M.D.; Peter L. Scardino, M.D.; Patrick C. Shea, Jr., M.D.; Robert H. Vaughan, M.D.

**PUBLICATIONS COMMITTEE**

J. G. McDaniel, M.D.; George H. Alexander, M.D.; George R. Dillinger, M.D.; John Kirk Train, M.D.; A. W. Simpson, M.D.; John T. Mauldin, M.D.; John S. Atwater, M.D.; C. R. Andrews, M.D.

**THE ASSOCIATION**

George H. Alexander, M.D., *Pres.*; Walter E. Brown, M.D., *Pres.-Elect*; J. G. McDaniel, M.D., *Past Pres.*; Charles R. Andrews, Jr., M.D., *Chm. of Council*; John T. Mauldin, M.D., *Sec.*; John S. Atwater, M.D., *Treas.*; J. Frank Walker, M.D., *Speaker*; Mr. Milton D. Krueger, *Exec. Sec.*; Mr. James M. Moffett, *Asst. Exec. Sec.*; Mrs. Catherine Wooten, *Asst. Exec. Sec.*

THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and copyrighted, 1965, by the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309. Published monthly under the direction of the Council of the Association. Subscription rate: \$7 per year; \$1 per single copy. Second-class postage paid at Atlanta, Georgia.

**Special Article**

LORD, MAKE US RICH AND HONEST George H. Alexander, M.D., President, Medical Association of Georgia . . . . .	143
--	-----

**Scientific Articles**

PNEUMOPERITONEUM AS AN ADJUNCT TO LOBECTOMY John B. Blalock, M.D. . . . .	146
FAILURE TO DIAGNOSE HYPERTHYROIDISM Dan Burge, M.D. . . . .	150
SULFADIAZINE PROPHYLAXIS AGAINST RHEUMATIC FEVER DURING PREGNANCY: ITS SAFETY AS REGARDS THE INFANT Anne D. Morgan, M.D. and Nanette Kass Wenger, M.D. . . . .	153
ADAMANTINOMA OF THE TIBIA Ernest G. Edwards, M.D. . . . .	156

**Editorials**

INTERSTITIAL PULMONARY EDEMA . . . . .	159
"MEDICARE"—THE SECOND HALF OF A LONG BALL GAME . . . . .	159

**Features**

Cancer Page . . . . .	161
Heart Page . . . . .	162
Legal Page . . . . .	163
Mental Health Page . . . . .	165
Abstracts . . . . .	166

**The Association**

Deaths . . . . .	169
Societies . . . . .	169
Personals . . . . .	169
Advertising Index . . . . .	48A
Calendar . . . . .	152

**Cover**

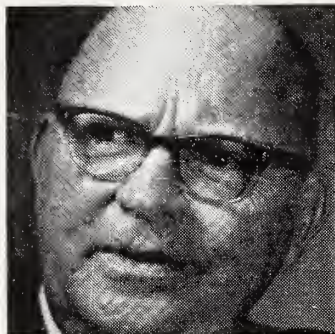
A Lines and B Lines of Kerley are seen in a patient with early congestive heart failure. Illustration from the Departments of Radiology and Medical Illustration, Emory University School of Medicine, Atlanta.



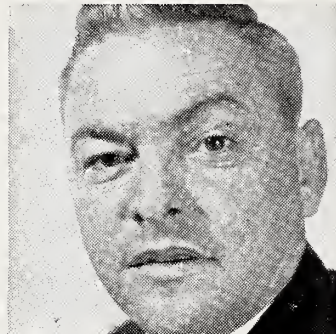
J. H. Hudson, Jr.—Augusta-Macon



J. B. Gardner—Rome



J. H. Butler—Atlanta



C. B. Jordan—Savannah

## “We’re puzzled”\*

... why some physicians use synthetic preparations or thyroglobulin  
 ... why some use nonbrand thyroids or write “thyroid U.S.P.”  
 ... when **ARMOUR THYROID** offers so many more advantages

- |   |  |  |                                  |
|---|--|--|----------------------------------|
| 1. useful PBI results—not possible with synthetic or extracted preparations | 2. complete thyroid therapy—containing both thyroxine and triiodothyronine <i>in natural ratio</i> | 3. uniform potency—doubly assayed, chemically and biologically | 4. predictable clinical response |
|   |  |  | 5. proven stability              |
|   |  |  | 6. lowest cost                   |

**Only ARMOUR THYROID gives you all these 6 advantages.**

That’s why it’s important to specify

\*Your Armour representatives

# ARMOUR THYROID

#### RELATED ARMOUR PRODUCTS:

Thyrar® (Beef Thyroid) Thytropar® (Thyrotropin)



**ARMOUR PHARMACEUTICAL  
COMPANY • KANKAKEE, ILLINOIS**

**NEW**—for a continuous supply of Armour Thyroid for you or your immediate family simply complete and return this coupon

Gentlemen: Please send my first bottle of 100 Armour Thyroid tablets offered on your new continuous Physicians Personal Use Program.

\_\_\_\_\_. M.D.

\_\_\_\_\_  
ADDRESS

CITY	STATE	ZIP CODE
1/4 gr.	1/2 gr.	1 gr.
2 gr.	3 gr.	5 gr.

Please circle potency requested.



## Lord, Make Us Rich and Honest

George H. Alexander, M.D., *Forsyth*  
President, Medical Association of Georgia



WHEN MY MOTHER was a young girl, she went to Albany, Georgia, to live with her aunt who had no children. The husband of her aunt was a former Confederate General and he became Mayor of his City and a Superior Court Judge.

This "Uncle Gib" was quite a character in many ways—one of his delights being derived by teasing "Auntie." Quite often when they would sit down for a meal he would ask the blessing by simply saying: "Lord, make us rich and honest." "Auntie" would remonstrate with him about this, but to no avail.

### In Grace and Religion

There came the occasion when some very proper and dignified guests came for dinner. When they were all seated at the table with their heads bowed, "Uncle Gib" said, "Lord, make us rich and honest"—and then after a pause he added—"rich in Thy Grace and honest in our religion"—much to the relief of "Auntie" and to the delight of the guests.

For the purpose of this talk, I think we might paraphrase a bit and say: "Lord, make us rich in Thy Grace and in our Heritage and Traditions. Also, we ask Thy help in keeping us honest in our convictions."

Using the foregoing story as a point of departure, there are some things which I would like to discuss with you briefly.

### Inherited Tradition

We physicians in Georgia and in our great country are certainly rich in His Grace and we have inherited a background rich in tradition. This background is well exemplified in our Hippocratic Oath and in the Code of Ethics of the American Medical Association to which we all subscribe.

Further exemplification may be found in a review of some of the more recent activities of our Association for the well-being of our State and its citizens.

The Milledgeville Hospital Study Committee is an outstanding example. We are all familiar with the "Schaefer Report" which served as the "launching pad" for improving the plight of the Milledgeville State Hospital and of our state's mentally ill people.

The Act to implement the Kerr-Mills program in Georgia was passed in 1961 with the support and endorsement of MAG, and we have continued to work for its full implementation.

The Georgia Hospital-Medical Council was organized under the sponsorship of the MAG Hospital Relations Committee. This Council has done a tremendous job in setting standards for and inspecting and accrediting small hospitals. More recently a similar program has been started for the nursing homes in Georgia.

The Council has also served as a mediation board in problems involving relationships between hospital medical staffs, governing boards and administrators.

A more recent, excellent example of the convictions held by our profession can be found in the "Eldercare" proposal of our American Medical Association. You are well familiar with the details of this proposed program and they will not be discussed at this time. This plan was honest in its inception and in its proposals. Why not the AMERICAN WAY, allowing and expecting those able to pay all their health care costs to do so, while allowing those able to pay part to do so and, at the same time, providing at government expense for those unable to provide for themselves? There should be no "handout" for those who do not need it.

## Lord, Make Us Rich and Honest/Alexander

Unfortunately, when the House of Representatives passed the administration's Health Care Bill, it made the passage of "Eldercare" most unlikely. However, we must continue to work to salvage as much as possible of the principles in which we believe.

I must also remind you that our AMA House of Delegates has authorized a study to determine the feasibility of a program of care based upon need for those *below* the age of 65.

Lord, help us to be honest in our convictions and have the courage to stand by them.

### Preservation of Tradition

The foregoing, I feel, and I believe you will agree with me, involves the preservation of the traditional way of American life. Some comment is in order concerning those traditions pertaining to our profession and our relationship to our patients, our communities and our governments.

It shouldn't be necessary, but I will say that we should continue our efforts to preserve inviolate the physician-patient relationship. All of us are aware of the need for more doctors who are willing to train for and do "family practice" not only in the less populous areas of our state, but also in the heavily populated areas. The decreasing number of physicians entering this type of practice is leaving a great gap and is largely responsible for our deteriorated "public image."

This problem was graphically brought out by an article in *Medical Economics* under date of October 19, 1964. According to this article, the number of M.D.'s in private practice increased in 1964 over the number in 1960, whereas, in the same period there was a decrease in the number of Generalists as well as the number of Internists and Pediatricians.

### A Responsibility

We have a responsibility to our communities to do all we can to reverse this trend. I realize that we certainly need highly trained and skilled men in all of the specialties and sub-specialties in which they are being trained but, in my opinion, and in the opinion of many others, too many men are entering those fields of practice and too small a portion of the total product of our medical schools is finding its way into family practice where the whole patient may be treated.

A step in the right direction was made this past January. Under the leadership of our President, Dr. J. G. McDaniel and Dr. Tom Goodwin, Chairman of our Board of Medical Education, the Georgia Conference on Medical Education was held. This Conference took place at Callaway Gardens and

included 30 practicing physicians and 15 faculty representatives from each of our Medical Schools.

I feel that the liaison produced was excellent and resulted in a better insight on the part of both groups into the problems of the other. It is my hope that another Conference can be held during the coming year, and as often thereafter as practical and necessary—perhaps on an annual basis.

### Para-Medical Personnel

In connection with these Conferences, I would like to comment on the problem of para-medical personnel. Recently, I have been privileged to serve on the newly created Dean's Medical Alumni Advisory Council for the Emory School of Medicine. There has been a great deal of discussion by this Council concerning the para-medical personnel problem and the need for more trained people in these fields. It is felt that while there is such a great need for more doctors and that such need will increase in the future, it will continue to be a tremendous problem for our medical schools to train them in sufficient numbers. For this reason, it has been recommended by this Emory Council that the Medical School undertake a program of training for these para-medical people. To do so, it will be necessary that the medical schools abandon the concept that such training puts them in the position of operating a "trade school."

### A Broadened Program

These para-medical people should remain under the direction and supervision of Doctors of Medicine. Therefore, it would be unwise for a separate examining and licensing program to be set up for them as it might well result in efforts to set up laboratories and services without proper medical supervision. For the foregoing reason, it is felt that certification would be preferable to licensure. Our larger hospitals are also in a position to operate these schools as are many of the larger clinical laboratories—and many do—but perhaps the program needs to be broadened.

Looking to the future—the physician will have to learn to be "Captain of a larger Team."

It is recommended that the MAG Board of Medical Education and the Board of Legislation work with representatives of our medical schools and hospitals in planning such a training program. This could well be an important facet of the next MAG Medical School Conference on Medical Education when more detailed planning may be discussed.

You will recall that earlier our Code of Ethics was mentioned. Most of our profession have an inherent sense of right and wrong and try to live by it. Our Code of Ethics puts down in "black and



white" the principles which should guide us in our conduct in relation to our patients, our community and our fellow physicians.

I wonder how many of us occasionally take the time to refresh ourselves as to what is contained in this Code. We should all take the time to do this as often as necessary to keep these principles fresh in our minds. While the vast majority of physicians abide by our Code, unfortunately we have an occasional maverick who will give the profession a black eye. We should always have the courage to stand by the principles enunciated in the Code and to stand behind our Professional Conduct Committees whenever it is necessary for them to act.

I urge that the MAG Professional Conduct Committee work with the constituent society committees, and where indicated to cooperate with our State Board of Medical Examiners in seeing that justice is obtained. This should be done whether the problem involves physician with physician relationship or physician-patient relationship or a breach by a physician of the Medical Practice Act. In the foregoing way, we can go far in upholding the honor and dignity of our profession. I would like to further recommend that during the coming year that all of our constituent societies devote one meeting to a program on medical ethics.

### Aid and Counsel

Among the responsibilities of medicine, I feel that we should, in the coming year, give our aid and counsel to those working on such problems as juvenile delinquency, our climbing crime rate, marriage mills and high divorce rate. Many problems remain which are more closely related to medicine—such as, cancer, arthritis, cardiovascular disease and the increase in VD and mental illness. I want to urge the proper Boards or Committees of MAG to cooperate and work with and support the various organizations addressing themselves to the alleviation of these problems.

There is a responsibility at the community level which needs to be filled more adequately. When I was serving on the Georgia Hospital-Medical Council, some inspection reports brought out the fact that inadequate provision had been made for any emergency service at a few hospitals. The medical staff of any community hospital has a responsibility to see that such coverage is available at all times, and I urge all local medical societies and/or medical

staffs to take necessary steps to see that emergency coverage is adequate.

Since I am drawing near the close of this speech, I would like to tell you a story of the doctor who quite frequently served as toastmaster at important dinners. He was introducing the honored guest on one occasion, at which time his wife was observed to reach into her purse, take out her lipstick and print in large letters across her napkin the letters KISS, after which she held the napkin up for him to see.

When the honored guest acknowledged his introduction, he commented that he was touched and moved by such a public display of affection between a man and his wife as he had just witnessed, when the wife printed the letters KISS upon her napkin and held it up for her husband to see. The toastmaster replied that the guest just didn't know what those letters meant—that the real meaning was "KEEP IT SHORT, STUPID." I am afraid it is late for me to keep this short and as I look out and see Miriam in the audience, I get the feeling that she might be thinking that I should get the "HOOK."

### To Live With It

Finally, I would like to emphasize that whatever system of health care is evolved, we have a responsibility and obligation to live with it. At the same time, we must do our utmost to preserve high standards of patient care and the traditional physician-patient relationship. Also we must, by all means, continue our fight for the modification of the program in such a way as to bring it into line with the principles in which we believe, and also with the possible inclusion of those *in need* below the age of 65.

Right here, I would like to quote our AMA President, Dr. Donovan Ward, when in February of this year he said to the special meeting of the AMA House of Delegates: "It is never too late to pass good legislation and to defeat bad legislation. The only one thing in this historic decision . . . *the only thing* . . . that may truly come too late, is regret."

In concluding, let me say that in our efforts to do some of the things discussed, it will be necessary to stand by our convictions and to have the courage to honestly work and fight for them. If we will but do this, then we may continue to be—"Rich in His Grace," and rich as well as honest in our heritage and traditions.

\* \* \*

Export sales of drugs reached a record of \$290 million in 1964, up 7.8% from 1963, according to a re-

port from the U.S. Department of Commerce. Drug imports dropped 14.6% to \$41 million.

# PNEUMOPERITONEUM AS AN ADJUNCT TO LOBECTOMY

John B. Blalock, M.D., *New Orleans, Louisiana*

- This procedure can be used as a space-reducing mechanism with a high degree of effectiveness and a minimum of dysfunction.

EARLY RESUMPTION of normal activity after pulmonary resection depends on prompt healing of the entire operative area and restoration of the best possible cardiorespiratory function. We are constantly assessing all measures available to insure such an outcome. In the case of pneumonectomy the measures are fairly limited and almost stereotyped. Firm closure of a well vascularized bronchial stump and systemic administration of antibiotics to prevent infection in the pleural space are the hallmarks of management of wounds in such cases. In partial resections in which it is necessary to restore a functioning hemithorax to ventilate the remaining pulmonary tissue, one or more of several maneuvers is used. In contradistinction to acceptance of a residual dead space in the hemithorax, as in pneumonectomy, all efforts are made to obliterate the dead space and to insure prompt sealing of the bronchial stump and of any parenchymal air leaks that may be present.<sup>1</sup> The pleural space must be obliterated by expansion of the remaining pulmonary tissue and reduction in the boundaries of the hemithorax. With adequate pulmonary suction the remaining lobe rapidly assumes its maximum volume.

## Fear of Overinflation

The fear that overinflation of pulmonary tissue is deleterious to its function seems to have been largely dispelled,<sup>2,3</sup> and although we believe that overdistension of normal pulmonary tissue does increase the residual air and does not enhance its respiratory function, we do not hesitate to employ

measures to insure its maximum distention. Immediate reexpansion is best accomplished by post-operative pleural suction catheters. One cannot anticipate that a remaining lobe can immediately assume the shape and volume of an entire lung and, therefore, adjustment in the boundaries of the pleural space is called into play. The natural occurrences are shifting of the mediastinum, upward displacement of the diaphragm, and splinting of the bony chest wall with narrowing of the intercostal spaces.

Mediastinal shift is deleterious to cardiorespiratory function and its occurrence is discouraged by methods directed toward one or the other boundaries, the bony chest wall, or the diaphragm. In the former category are the various types of thoracoplasty and plombage. These measures reduce the volume of the hemithorax significantly and have minimal detrimental effect on respiratory function.<sup>4-7</sup> On the other hand, they do entail additional operative time and trauma, their effect is more or less permanent, and the incidence of complications is significant.

## Space Reducing Procedures

The remaining boundary of the hemithorax, the diaphragm, is the most mobile and yielding one, and a variety of procedures are available to utilize these features in space reducing procedures.<sup>5,8-10</sup> One of the most time-honored of these is phrenic crush or phrenic exeresis by which either fairly prolonged but eventually remitting paralysis or permanent paralysis of the diaphragm can be effected. This does significantly reduce the volume of the pleural space, but it is bought at a high cost in terms of pulmonary function of both lungs, and it greatly impairs the highly important coughing ability in the postoperative period.<sup>9,11,12</sup> Another operative procedure directed

*Presented at the Joint Session of the Georgia Thoracic Society and the Georgia Chapter, American College of Chest Physicians, May 4, 1964, Macon, Georgia.*

*From the Department of Surgery, Ochsner Clinic, New Orleans.*



toward the diaphragm, which actually has enjoyed little popularity and in effect probably amounts to diaphragmatic paralysis, is transplantation of the periphery of the diaphragm to a higher level on the thoracic wall.<sup>5</sup> This has been done by detaching the diaphragm at its point of insertion on the bony chest wall and resuturing it at a higher level.

There is one remaining measure by which the extreme motility of the diaphragm can be used as a space-reducing mechanism with a high degree of effectiveness and a minimum of dysfunction; that is, pneumoperitoneum. This procedure, dating from the days of collapse therapy for tuberculosis, has been suggested in combination with diaphragmatic paralysis as a means of obliteration of dead space in patients postoperatively.<sup>11</sup> To the best of my knowledge credit for its extensive use as an adjunct to pulmonary resection goes to Buechner, Ziskind, and Strug.<sup>12</sup> These physicians recognized that beneficial effects occurred in patients undergoing pulmonary resection, who preoperatively had been subjected to pneumoperitoneum as part of collapse therapy. They noted that in the postoperative roentgenograms there was considerable reduction in space in the hemithorax of the operative side by the somewhat greater accumulation of the pneumoperitoneum beneath the diaphragm on that side. The incidence of postoperative complications was significantly reduced. Being exceedingly anxious to employ any practical measures to prevent the occasional distressing complication of pulmonary resection, I began instituting pneumoperitoneum at operation in selected patients five years ago.

### Changing Indications

It has been interesting to notice the changing indications for lobectomy during the past decade. Whereas tuberculosis was formerly one of the most frequent indications and chronic infectious diseases, such as bronchiectasis, were still common, at least in our experience lobectomy for primary bronchogenic carcinoma was done only in highly selected cases. In more recent years lobectomy has been performed for carcinoma probably as an admitted palliative procedure sometimes in patients in whom pneumonectomy was contraindicated because of diminished pulmonary function. In a number of such patients it has been possible to perform lobectomy with gratifying long-term results. These are usually old patients in whom diminished pulmonary function due to aging and often also due to associated emphysema makes them somewhat precarious operative candidates. They are not good subjects for the concomitant thoracoplasty or plombage measures, or for diaphragmatic paralysis, and adequate pneumoperitoneum is a most valuable adjunct in the

operative therapy. In none of these patients has preoperative pneumoperitoneum been instituted and in none of them has it been necessary to continue it after discharge from the hospital.

Pneumoperitoneum has been utilized in 26 selected cases of lobectomy in which difficulty in obliterating the dead space without the use of some adjunctive therapy was anticipated. In 23 patients pneumoperitoneum was instituted under direct vision through an opening in the diaphragm through which a catheter was inserted into the free peritoneal cavity. In two patients with suspected bronchogenic carcinoma in whom the status of the liver had been assessed before thoracotomy, pneumoperitoneum was instituted through a polyethylene catheter, which was left in the subphrenic space at the time of limited laparotomy. In one patient it was instituted by Potter needle through the abdominal wall.

### Danger Cannot Be Overemphasized

The danger of instituting pneumoperitoneum by needle puncture through the diaphragm cannot be overemphasized.<sup>12,13</sup> I know of one fatality from air embolism as the result of this procedure. It has become obvious from experience with this technic that larger and larger amounts of air have been used. The necessity for refills can be determined during the postoperative period and this can be safely effected by Potter needle through the abdominal wall. There is considerable individual variation in the rate of absorption of air instilled in the peritoneal cavity. In some, the air has disappeared within a few days whereas in others it has remained for several weeks. I am aware of no deleterious effects of pneumoperitoneum and it is well tolerated by the patient. Seven of the 26 patients required from one to three refills of from 500 to 1500 cc. each. More recently we have usually instituted 2500 cc. of air at the operation. The indications for lobectomy were: primary carcinoma, 8 patients (6 of whom were between the ages of 60 and 74 years); tuberculosis, 5 patients; unresolved pneumonia, 4 patients; bronchoectasis, 3 patients; metastatic tumors, 2 patients; and 1 patient each with broncholithiasis, intrapulmonary bronchogenic cysts, carcinoid bronchial adenoma, and cryptococcosis. One patient with advanced drug resistant tuberculosis died during the postoperative period. Another required emergency treatment for atelectasis in the three remaining segments in the left hemithorax after lower left lobectomy and lingular resection for bronchiectasis; a year later the patient had a sterile air space between the diaphragm and the remainder of the left upper lobe which was obliterated by institution of a suction catheter. The remaining 24 patients had an uncomplicated postoperative course and most of them



left the hospital on the tenth to twelfth postoperative day.

The following cases illustrate when this maneuver can be used and the results obtained.

*Case 1:* A 50-year-old man had unresolved pneumonitis associated with infected bullous disease. Right upper lobectomy was performed. The anteroposterior and lateral views of the chest demonstrated an effective pneumoperitoneum.

*Case 2:* A 34-year-old man complained of periodic productive cough. A rather unimpressive area in the left lower pulmonary field was noted in the roentgenogram of the chest. Severe bronchiectasis involving the left lower lobe was demonstrated in the bronchogram. At left lower lobectomy severe sacculization of the bronchi was noted. Pneumoperitoneum provided an obvious aid in elevation of the left hemidiaphragm.

*Case 3:* A 51-year-old man had had episodes of recurrent hemoptysis. No abnormalities were detected in roentgenograms of the chest. A bronchogram demonstrated incomplete filling of the dorsal segmental bronchus on the right, and at right lower lobectomy, a broncholith, undoubtedly an eroded calcific lymph node in the dorsal segmental bronchus, was seen. Pronounced elevation of the diaphragm from pneumoperitoneum and absence of any necessity for mediastinal shift were demonstrated in anterior and lateral roentgenograms of the chest. A late postoperative film showed a satisfactory result.

*Case 4:* A 27-year-old woman had been known to have some abnormality of the left upper lobe since the age of six years. This was resected and proved to be an intrapulmonary bronchogenic cyst. Pneumoperitoneum was instituted at operation, and a late roentgenogram of the chest showed a good result.

*Case 5:* A 42-year-old woman had a classical history of chronic left lower lobe bronchiectasis, which was confirmed by bronchography. Left lower lobectomy and lingulectomy were performed. The postoperative course was complicated by development of atelectasis in the remaining three segments in the left hemithorax with pronounced mediastinal shift. This subsided after the bronchus was aspirated at bronchoscopy. Anteroposterior and lateral roentgenograms of the chest showed the effectiveness of the pneumoperitoneum. The eventual result was good with preservation of function of the residual part of the left lung.

*Case 6:* A 73-year-old man had bronchogenic carcinoma of the left upper lobe. A lateral roentgenogram of the chest indicated severe enlargement of the thoracic cage. This emphasized the likelihood of

a dead space after lobectomy. The patient withstood left upper lobe resection, and institution of pneumoperitoneum was satisfactory. A postoperative roentgenogram of the chest with pneumoperitoneum in effect demonstrated the efficacy of this measure in elevating the diaphragm. A satisfactory postoperative result was obtained.

*Case 7:* This 57-year-old man had left upper lobe tuberculosis. A lateral roentgenogram demonstrated severe enlargement of the thoracic cage. The left upper lobe was resected and pneumoperitoneum was instituted. The effectiveness of the pneumoperitoneum was demonstrated in the anteroposterior and lateral views. A satisfactory result was obtained.

## Summary

It is desirable to use some form of space filling procedure in some patients undergoing lobectomy. The amount of operative trauma, duration of the available procedures, and their deleterious effect on pulmonary function vary considerably. Pneumoperitoneum instituted at operation is a highly effective method of obtaining this desired result with a minimum of time, risk, operative trauma, and deleterious effect on cardio-respiratory function. This procedure is particularly effective in old patients who are not candidates for complete pulmonary resection for carcinoma because of impaired pulmonary function but can withstand the more limited lobectomy if it can be performed without too much risk of development of complications. In a limited series of 26 patients pneumoperitoneum seems to have helped accomplish this end.

## REFERENCES

1. Chamberlain, J. M. and Ryan, T. C.: Segmental resection in pulmonary diseases. *J. Thoracic Surg.* 19:199-206 (Feb.) 1950.
2. Gaensler, E. A. and Strieder, J. W.: Progressive changes in pulmonary function after pneumonectomy: influence of thoracoplasty, pneumothorax, oleothorax, and plastic sponge plombage on side of pneumonectomy. *J. Thoracic Surg.* 22:1-34 (July) 1951.
3. Bergen, F.: Indications and results in lung surgery as revealed by functional study. *Acta chir. scandinav.* 111: 214-225, 1956.
4. Bjork, V. O.: Thoracoplasty; new osteoplastic technique. *J. Thoracic Surg.* 28:194-211 (Aug.) 1954.
5. Bjork, V. O.: Surgical treatment of lower lobe tuberculosis. *J. Thoracic Surg.* 31:655-671 (June) 1956.
6. Stead, W. W.: Physiologic studies following thoracic surgery; immediate effects of upper lobectomy combined with 5-rib thoracoplasty. *J. Thoracic Surg.* 25:194-204 (Feb.) 1953.
7. Wilson, N. J.; Armada, O.; Vindzberg, W. V., and O'Brien, W. B.: Extraperiosteal plombage thoracoplasty; operative technique and results with 161 cases with unilateral surgical problems. *J. Thoracic Surg.* 32:797-819 (Dec.) 1956.
8. Cournaud, A. and Richards, D. W., Jr.: Pulmonary insufficiency; discussion of physiological classification and presentation of clinical tests. *Am. Rev. Tuberc.* 44:26-41 (July) 1941.
9. Wright, G. W.; Place, R., and Princi, F.: The physiological effects of pneumoperitoneum upon the respiratory apparatus. *Am. Rev. Tuberc.* 60:706-717 (Dec.) 1949.



10. Siebens, A. A.; Pietraszek, C. F.; Weaver, J., and Storey, C. F.: Some effects of pneumoperitoneum on respiration in patients with pulmonary tuberculosis. *Am. Rev. Tuberc.* 70:672-688 (Oct.) 1954.

11. Bickford, B. J., et al.: Lung resection for pulmonary tuberculosis. *Thorax* 6:25-42 (March) 1951.

12. Buechner, H. A.; Ziskind, M. M., and Strug, L. N.: Pneumoperitoneum as a space-occupying procedure in conjunction with pulmonary resection. *J. Thoracic Surg.* 33:229-236 (Feb.) 1957.

13. Higgins, G. A. and Batchelder, T. L.: Air embolism following transdiaphragmatic pneumoperitoneum. *J. Thor. Cardio. Surg.* 41:158-161 (Feb.) 1961.

## NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Name</i>	<i>Address</i>
Bates, John G. Active—Randolph-Stewart-Terrell	201 Randolph Street Cuthbert, Georgia	Haraszti, Rosalie B. Associate—Fulton	Communicable Disease Ctr. Atlanta, Georgia 30322
Bickerstaff, James W., Jr. Active—Ware	410 Zachry Street Waycross, Georgia	Herndon, John W. Active—Coffee	Ocilla Road Douglas, Georgia
Brake, Charles A. Active—Fulton	1365 Clifton Road, N.E. Atlanta, Georgia 30322	Long, Harold W. Active—Ocmulgee	Foster Street Eastman, Georgia
Brewton, Samuel A., Jr. Active—Upton	612 West Gordon Road Thomaston, Georgia	Patterson, Homer S. Active—DeKalb	5020 Buford Highway Chamblee, Georgia
Casey, Jesse Frank Active—Fulton	47 Trinity Ave., S.W. Atlanta, Georgia 30303	Patterson, W. O., Jr. Active—Muscogee	1953 Seventh Ave. Columbus, Georgia
Crawford, Glenn D. Active—Cobb	2404 Marietta Road Austell, Georgia	Solana, Jose L. Active—Fulton	136 11th Street, N.E. Atlanta, Georgia 30309
Crimmins, L. T. Active—Dougherty	412 Third Avenue Albany, Georgia	Taylor, William M. Active—Muscogee	Medical Center Columbus, Georgia
Dennis, Brown W. Active—Fulton	727 Juniper St., N.E., Apt. 8 Atlanta, Georgia 30309	Tomblin, Collis N. Active—Muscogee	1226 Third Ave. Columbus, Georgia
Farrell, Robert A. Active—Fulton	300 Boulevard, N.E. Atlanta, Georgia 30312	Tryon, William E. Active—Cobb	2380 Roswell Road Marietta, Georgia
Ferrell, M. Lynn Active—Oconee Valley	325 E. Broad Street Sparta, Georgia	Westermann, John J., Jr. Active—Glynn	Sea Island, Georgia
Hall, John C. Associate—Fulton	Dispensary—NAS Atlanta Marietta, Georgia		

## “KEY FACTS” PUBLISHED BY PHARMACEUTICAL MANUFACTURERS ASSOCIATION

A wide array of facts and figures in the prescription drug industry is contained in a new edition of **KEY FACTS** published by the Pharmaceutical Manufacturers Association.

Introduced by PMA two years ago as the industry's basic information pamphlet, it contains nine up-to-date charts which underscore trends in the conquest of disease and the industry's contributions to the health team.

To facilitate its use as a handy reference source for speakers, writers, government officials, and others concerned with the industry, the facts are categorized under

five headings: prices, competition, safety, research and accomplishments.

The PMA public information office is distributing copies of the three-color pamphlet extensively throughout the drug industry and also to science writers, medical and pharmacy schools, and other important audiences.

Copies are available on request from: Public Information Office, Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.

# FAILURE TO DIAGNOSE HYPERTHYROIDISM

Dan Burge, M.D., *Atlanta*

- This condition is frequently overlooked in cardio-vascular, and so called "emotional" disorders.

**H**YPERTHYROIDISM should be an ideal entity for clinical diagnosis. Characteristic signs and symptoms are exhibited and laboratory confirmation is available. These suggest that a high degree of accuracy should be obtained. However, most physicians can recall instances of failure to make the diagnosis. For this reason it should prove profitable to review the means of making this diagnosis and the causes of failure to do so. The following description of the clinical picture may be confirmed by perusal of standard texts.<sup>1,2,3</sup>

The symptoms of Grave's disease are nervousness, palpitation, weakness, weight loss, diarrhea or frequent normal stools, large appetite, intolerance for heat, increased tolerance for cold, menstrual disturbance, and pressure symptoms from an enlarged gland.

## Cardinal Signs

The cardinal signs are increased psychomotor activity, muscular weakness, fine tremor, lid lag, failure of normal convergence of the eyes, increased sweating, warm moist palms, fine texture of skin and hair, premature greying, tachycardia, wide pulse pressure, cardiac arrhythmia (particularly atrial fibrillation), thyroid bruit, enlarged thyroid gland, and exophthalmos. Often the patient is able to date the onset of symptoms to a time of emotional stress or shock. "Nervousness" in this disease frequently means increased bodily tension and tremor. Insomnia may be the presenting complaint. Palpitation can mean awareness of tachycardia, cardiac arrhythmia or awareness of the full bounding pulse due to a wide pulse pressure. Weakness and consciousness of weakness occur in greatly varying degree. Quadriiceps weakness noted on climbing steps is a frequent complaint. Rarely, profound generalized myasthenia is seen. Weight loss, large appetite, and diarrhea of hyperthyroidism may be obscured by the fluid re-

tention, anorexia and constipation of accompanying cardiac decompensation. At times anorexia may replace polyphagia as a manifestation of relative thiamine deficiency secondary to increased metabolic demand. Increased thirst is an occasional presenting symptom. This is seemingly from increased fluid loss secondary to increased metabolic activity. Constipation when seen in this disease may be due to similar dehydration.

It is unusual for a patient to exhibit all of the symptoms and signs of this disease. It is not unusual for a single symptom or sign to dominate the clinical picture. There is no universally occurring evidence of hyperthyroidism.

Since the degree of hyperfunction of the thyroid waxes and wanes in cyclic fashion, the severity of the clinical picture will vary correspondingly. Thus the diagnosis may be apparent at one time and obscure several months earlier or later. This fact should temper judgment of the diagnostic failures to be considered next.

## Method of this Study

One hundred and fifty charts of patients with hyperthyroidism were examined. The diagnosis seemed definitely established in each on clinical grounds, supported by laboratory evidence and in many by unequivocal response to appropriate therapy. These records were obtained from the hospital and out-patient files of the Emory University, Crawford W. Long, and Grady Memorial Hospitals and from our own practice. Examination of these charts revealed 33 instances in which the diagnosis had been missed at first by one or more physicians. This obviously has no statistical value. Only those cases were included in which the diagnostic error was apparent from the record. Many of the 150 cases were admitted for thyroid surgery with no account of diagnostic error which may have occurred. It is



CONDITIONS

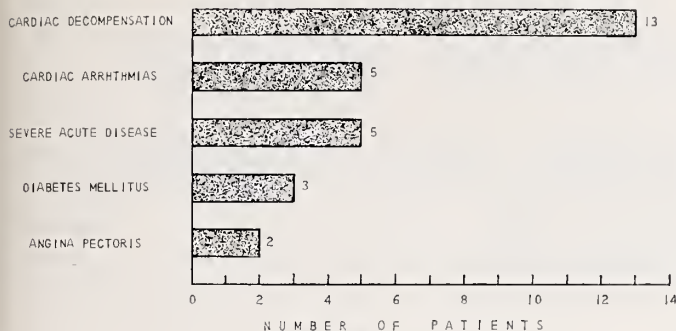


FIGURE 1

also likely that many instances of hyperthyroidism remain undiagnosed; the patient finally dying of the disease and its complications, or of some unrelated condition. The 33 records of definite original diagnostic failure were examined in order to determine the factors which seemed to prevent prompt identification of the disease. The best clues seemed to be the recorded impressions prior to the realization of hyperthyroidism. These represented the physicians' ideas in accounting for the patients' symptoms and signs.

### Results

These diagnoses have been summarized in two groups: (1) Complicating conditions which apparently turned attention from hyperthyroidism; and (2) Diseases for which hyperthyroidism was mistaken (See Figure 1).

There were 13 cases who were being treated for congestive heart failure. The etiology of the decompensation was thought to be hypertensive, arteriosclerotic, or rheumatic heart disease in each of these. After thyroid disease was considered, convincing clinical and laboratory evidences were recorded. Of the five arrhythmias, three were chronic fibrillation, one was paroxysmal auricular fibrillation, and the fifth case exhibited both paroxysmal atrial tachycardia and paroxysmal atrial fibrillation. In two cases the physician's attention was directed exclusively toward coexisting angina pectoris. Two cases listed with "severe acute diseases" had acute myocardial infarction. Thus 18 cases of the 33 failures exhibited one or more of the cardiac complications just mentioned.

The cases listed together as "severe acute diseases" included myocardial infarctions, multiple pulmonary infarction, peptic ulcer with partial obstruction, severe hypertension and visual disturbances, and rheumatoid arthritis. In this group dramatic symptoms demanded the physicians' attention. Hyperthyroidism was diagnosed soon after the acute symptoms had begun to subside. In three cases, co-existing diabetes was given entire credit for symptoms which were in

CONDITIONS

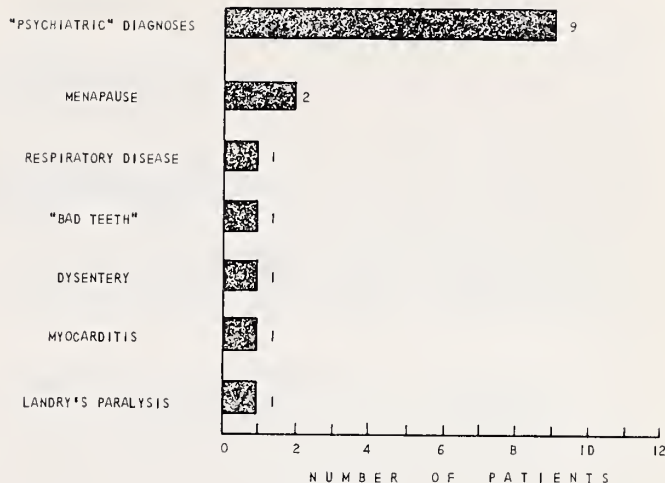


FIGURE 2

part due to hyperthyroidism, particularly large appetite, weakness, and weight loss. Difficulty in controlling the diabetes probably led to awareness of hyperthyroidism (See Figure 2).

This group was dominated by diagnoses implying a functional origin for symptoms, later demonstrated to have an endocrine basis. Nervousness, nervous tension, psychasthenia and psychoneurosis were terms that were used in nine cases. In two instances the emotional instability, sweating, tachycardia and menstrual disturbances were attributed to menopause. Bad teeth were held responsible for weakness and weight loss in one case. These symptoms were later found to be a part of the classical picture of Grave's disease. Cough due to pressure from enlarged thyroid gland was attributed to lung disease. Recurrent diarrhea was originally called a chronic dysentery until the correct diagnosis was made. One case exhibiting severe toxic myopathy and tachycardia was called at first myocarditis. A similar case showed such profound weakness that Landry's paralysis was diagnosed. Another was thought to be in cardiac decompensation because of weakness and brawny edema over the abdomen and lower extremities. A consulting cardiologist pointed out normal venous pressure, normal size heart and absence of hepatic enlargement, and noted several evidences of hyperthyroidism. Brawny edema may be a feature of uncomplicated hyperthyroidism.

### Discussion

There are undoubtedly other conditions for which Grave's disease has been mistaken, such as the chronic wasting diseases. The dominant cause of error in the material examined, however, was failure to carefully consider hyperthyroidism in each instance of cardiac decompensation, cardiac arrhythmia, and coronary artery disease. Over half of the diagnostic errors fell in this group. Cardiac decompensation

## **HYPERTHYROIDISM / Burge**

pensation is an entity which satisfies the physician's urge to find something definite to treat. As previously stated, weight loss, large appetite and diarrhea due to over-active thyroid may be obscured by weight gain, anorexia, and constipation due to cardiac failure. Marked weakness attributed to one condition may be due to both. Since thyroid hyperfunction increases the cardiac burden, decompensation is often thus precipitated in heart disease of all types.

The other major stumbling block was found to be the assumption of a functional basis for the nervous tension, irritability, and cardiovascular evidences of hyperthyroidism. At times the psychic trauma which has precipitated thyroid dysfunction may be thought to be the basis of an emotional dis-

order. History and physical examination with thyrotoxicosis in mind will largely eliminate this and the other sources of error. There is a small group of patients in whom it may be very difficult to determine if this disease exists—clinical picture, P.B.I., radio-active iodine uptake, all being inconclusive. In this group therapeutic trial with anti-thyroid drugs is justified. No such case was included in the present study. Constant awareness of the possibility of hyperthyroidism should decrease our diagnostic failure rate. This is particularly true when confronted by cardio-vascular or "emotional" disorders.

21 Eighth Street, N.E.

### **BIBLIOGRAPHY**

1. Harrison, T. R.: *Principles of Internal Medicine*, Blakiston, 1950, (pp. 574-577).
2. Friedberg, C. K.: *Diseases of the Heart*, 2nd Ed., Saunders, 1956, (pp. 1004-1010).
3. Duncan, G. G.: *Disease of Metabolism*, 2nd Ed., Saunders, 1947, (pp. 925-928).

## **EIGHTH ANNUAL GROUP OF PHYSICIANS RECEIVE WYETH FELLOWSHIPS FOR TWO-YEAR STUDIES IN PEDIATRICS**

The Wyeth Fund for Postgraduate Medical Education has granted two-year residency Fellowships in pediatrics to 15 physicians, starting July 1, it was announced by Philip S. Barba, M.D., chairman of the Selection Committee and past president of the American Academy of Pediatrics.

Each year, the committee selects a group of physicians who are planning to do advanced study on the medical care of children. The Wyeth Fund awards each physician in the group a Fellowship of \$4800 toward a residency.

The Selection Committee is headed by Dr. Barba, who is Associate Professor of Pediatrics and Associate Dean of the University of Pennsylvania School of Medicine. Other members of the committee are John A. Anderson, M.D., Professor and Chairman, Department of Pediatrics, University of Minnesota School of Medicine; Crawford Bost, M.D., San Francisco pediatrician and Clinical Professor of Pediatrics at the University of California; Hugh A. Carithers, M.D., Jacksonville (Fla.)

pediatrician and Chief of Pediatrics, Jacksonville Hospitals' Education Program, Jacksonville; and Amos Christie, M.D., Professor and Chairman, Department of Pediatrics, Vanderbilt University School of Medicine, Nashville, Tenn.

Eligible to apply for Fellowships beginning July 1, 1966, are interns, physicians who have recently completed internships, physicians leaving the armed services or the U.S. Public Health Service, and research Fellows.

The Selection Committee must receive applications for Fellowships by December 1, 1965. Requests for applications and inquiries concerning the program should be sent to the Selection Committee chairman, Dr. Philip S. Barba, University of Pennsylvania School of Medicine, Philadelphia, Pa. 19104.

Wyeth Fellows are free to choose their place of residency from institutions accredited by the Residency Review Committee of the American Board of Pediatrics and the Council on Medical Education and Hospitals of the American Medical Association.

## **1965 CALENDAR OF MEETINGS**

### **State**

May 1-3, 1966—112th Annual Session of the Medical Association of Georgia, Columbus.

### **Regional**

May 27-29—American Ophthalmological Society, Homestead Hotel, Hot Springs, Va.  
June 16-19—Society of Nuclear Medicine, Americana Hotel, Bal Harbour, Fla.  
June 28-July 1—American Orthopaedic Association, Hot Springs, Va.

### **National**

May 24-28—A Five Day Refresher Course in Pediatrics sponsored by the Children's Hospital of Philadelphia and the Department of Pediatrics, School of Medicine, University of Pennsylvania, Philadelphia, Pa.  
June 16—American Cancer Society, 1965 Scientific Session, Drake Hotel, Philadelphia, Pa.  
June 17-21—31st Annual Meeting of the American College of Chest Physicians, Waldorf-Astoria Hotel, New York City.  
June 20-24, 1965—American Medical Association, Americana Hotel, New York City.



# SULFADIAZINE PROPHYLAXIS AGAINST RHEUMATIC FEVER DURING PREGNANCY: ITS SAFETY AS REGARDS THE INFANT

Anne D. Morgan, M.D.  
Nanette Kass Wenger, M.D., *Atlanta*

- A review of clinical records of 100 infants delivered of 54 rheumatic mothers receiving sulfadiazine throughout pregnancy.

**S**ULFONAMIDE DRUGS have been implicated in the development of kernicterus in premature infants. It has therefore been questioned whether sulfadiazine prophylaxis against rheumatic fever, administered to the mother during pregnancy, might cause increased susceptibility of the newborn infant to kernicterus. This study was undertaken to determine if sulfadiazine, in the dose recommended by the American Heart Association<sup>1</sup> as prophylaxis for the mother against rheumatic fever, increased the incidence of kernicterus in the newborn infant.

## Review of the Literature

Silverman<sup>2</sup> demonstrated that sulfisoxazole, administered to premature infants, resulted in an increased incidence of kernicterus although the mean serum bilirubin level in these infants was no greater than that of infants who did not otherwise develop kernicterus. Johnson<sup>3,4</sup> administered sulfonamide drugs to newborn rats with comparable results.

Bilirubin is bound to plasma albumin in a manner similar to other organic anions, including sulfonamide drugs.<sup>5</sup> Sulfonamides therefore can compete with bilirubin for binding sites on albumin molecules, reducing the protein-bound plasma bilirubin. The free or uncoupled bilirubin diffuses more readily into extravascular spaces, especially tissues of the brain.

Kernicterus is due to the accumulation of unconjugated or free bilirubin in brain tissue. The relative inactivity at birth, especially in prematures, of the glucuronyl transferase system, normally responsible

for bilirubin conjugation and excretion, aggravates this tendency to hyperbilirubinemia.<sup>6</sup> Numerous other factors, including drugs other than sulfonamides, affect bilirubin metabolism.<sup>7</sup>

Kernicterus is characterized by jaundice, marked lethargy, poor sucking, diminished Moro reflex, opisthotonus, muscle twitching or convulsions, and cyanotic episodes.<sup>8</sup> The critical period for the development of kernicterus is the first week of life; approximately 70% of infants who develop kernicterus die in the first few days after birth.<sup>9</sup> Those infants surviving the neonatal period usually show significant neurologic abnormalities during the first year: seizures, extrapyramidal signs (choreo-athetosis), mental deficiency, and hearing loss.

Sulfonamides, as well as numerous other drugs, can cross the placental barrier.<sup>10</sup> Long-acting sulfonamides (sulfamethoxine and sulfamethoxyripyridazine) administered to the mother result in measurable blood levels in the infant for several days after birth.<sup>11,12</sup> Therefore, it is considered inadvisable to administer these long-acting sulfonamide drugs during the last trimester of pregnancy.

Blood sulfa levels of infants born to rheumatic mothers receiving prophylactic sulfadiazine during pregnancy have not been studied. It would be of interest to measure the blood sulfa levels of these infants, since the potential danger of their increased susceptibility to kernicterus has been suggested.

We reviewed the Grady Memorial Hospital Cardiac Clinic records of adult females receiving prophylactic sulfadiazine against rheumatic fever. Sulfadiazine was administered in a dosage of 0.5

From the Departments of Pediatrics and Medicine, Emory University School of Medicine, and the Cardiac Clinic, Grady Memorial Hospital.

gm. b.i.d. The records of all live births to the 54 mothers who had continued sulfadiazine prophylaxis throughout pregnancy up to the time of delivery were also reviewed.

### Results

There were 100 live births to the 54 females receiving sulfadiazine prophylaxis, 21 premature births and 79 full-term births (Figure 1). The incidence of prematurity was not significantly different from that of the general nursery population at Grady Memorial Hospital. Full-term infants were hospitalized from 1-5 days after birth, and premature infants until a weight of 5 lbs. was attained. None of the 100 infants developed evidence of kernicterus during their neonatal hospitalization. There was one neonatal death, a premature infant who died at age 23 days of acute bacterial meningitis and peritonitis.

Seven infants developed jaundice during the neonatal hospitalization (Figure 2). In two siblings, jaundice was due to Rh incompatibility; one infant required an exchange transfusion. One case of ABO incompatibility required exchange transfusion. Four infants developed jaundice after 36 hours of age. This was thought to be "physiologic" and required no treatment. The incident of "physiologic" hyperbilirubinemia in the infants of mothers who received sulfadiazine prophylaxis during pregnancy was not greater than that of other newborns at this institution.

Of the seven infants with neonatal jaundice, both siblings with the Rh incompatibility have been examined after age one year and appear normal. The infant with ABO incompatibility is apparently normal at age five years. The four infants with "physiologic" jaundice were seen at ages 2½ months, six months, nine months, and two years, respectively, and showed no neurologic abnormalities.

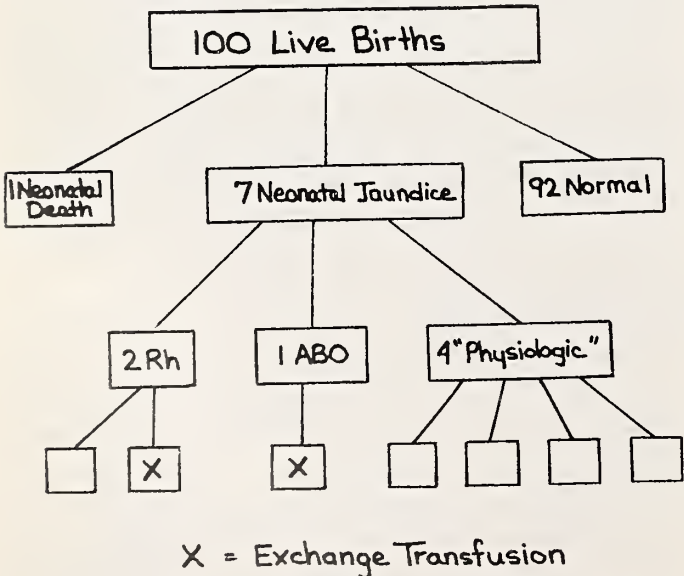


FIGURE 1  
The incidence of neonatal jaundice in the 100 live births to 54 females receiving sulfadiazine prophylaxis against rheumatic fever during pregnancy.

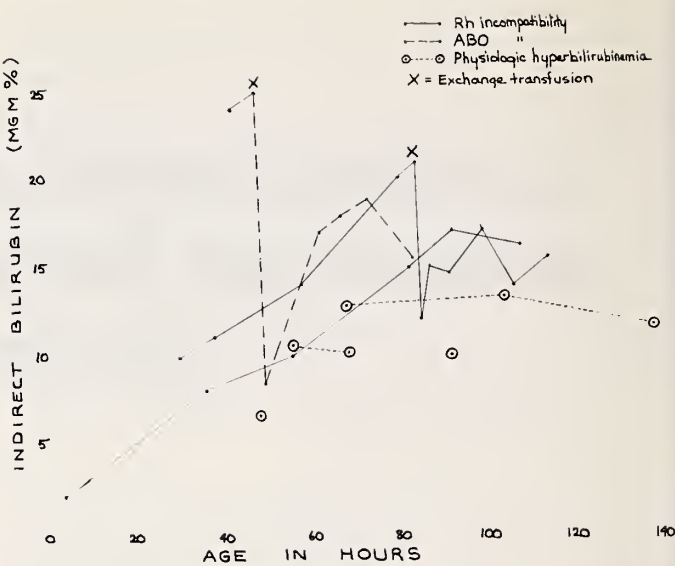


FIGURE 2  
The serum indirect bilirubin levels in the seven infants with neonatal jaundice.

There was no evidence of kernicterus in any infant in the study group. Eighty-four of the 99 infants who survived the neonatal period were subsequently re-examined at Grady Memorial Hospital. Fourteen of the remaining 15 infants were examined at a local Public Health Pediatric Center. One infant has been lost to follow-up. Seventy-two of these infants were re-examined after age one year and an additional 20 after age four months. However, complete neurologic examinations were not performed, and minor degrees of brain damage may not have been recognized; therefore, it can only be said that these infants have no gross neurologic deficit to date.

### Summary

The charts of 100 infants delivered of 54 rheumatic mothers receiving prophylactic sulfadiazine therapy throughout pregnancy have been reviewed. There is no evidence from this study that sulfadiazine prophylaxis against rheumatic fever administered to the mother during pregnancy resulted in an increased incidence of prematurity, hyperbilirubinemia, or kernicterus.

### REFERENCES

1. Prevention of Rheumatic Fever and Bacterial Endocarditis through Control of Streptococcal Infections, *Circulation* 21:151-155, 1960.
2. Silverman, W. A.; Anderson, D. H.; Blanc, W. A., and Crozier, D. N.: Difference in Mortality Rate and Incidence of Kernicterus among Premature Infants Allotted Two Prophylactic Antibacterial Regimens, *Pediatrics* 18:614, 1956.
3. Johnson, L.; Figueroa, E.; Garcia, M. L., and Newmark, H.: The Effect of Certain Substances on Bilirubin Levels and the Occurrence of Kernicterus in Jaundiced Rats, *A.M.A. J. Dis. Child.* 98:602, 1959.
4. Johnson, L.; Sarmiento, F.; Blanc, W. A., and Day, R.: Kernicterus in Rats with an Inherited Deficiency of Glucuronyl Transferase, *A.M.A. J. Dis. Child.*, 97:591, 1959.
5. Odell, G. B.: Dissociation of Bilirubin from Albumin and its Clinical Implications, *J. Pediat.* 55:268, 1959.
6. Yu, W. L., and Aldrich, R. A.: The Glucuronal Transferase System in the Newborn Infant, *Pediat. Clin. N. Amer.* 7:381, 1960.



7. Day, R. L.: Physiologic Jaundice—1961, *Pediat. Clin. N. Amer.*, 8:539-550, 1961.

8. Schaffer, A. J.: *Diseases of the Newborn*. Philadelphia and London: W. B. Saunders Co., 1960, pp. 572-575.

9. Sanford, H. N.: The Hemolytic Anemias of Infancy and Childhood. *Pediat. Clin. N. Amer.*, 9:442, 1962.

10. Hagerman, D. D. and Villee, C. A.: Transport Functions of the Placenta. *Physiol. Rev.*, 40:313, 1960.

11. Lucey, J. F., and Dolan, R. G.: *Physiologic Jaundice Re-examined—Symposium on Kernicterus*, Toronto: Toronto University Press, 1960.

12. Sparr, R. A., and Prichard, J. A.: Maternal and Newborn Distribution and Excretion of Sulfamethoxypyridazine (Kynex), *Obst. and Gyn.*, 12:131, 1958.

## COOPERATION IN DRUG INVESTIGATION

As the new drug is being introduced on the market and becomes generally available, the pharmaceutical manufacturer loses his tight control over its use, and a major part of the responsibility for the judicious application of the compound now rest with the medical profession and the scientific organizations and societies interested in drug therapy. It is therefore hoped that the many local, national, and international organizations which are concerned with effects and adverse reactions of drugs will join with the pharmaceutical manufacturer and the government agencies charged with surveillance of drugs in an effort to assure the most beneficial and the safest application of our modern chemical weapons against disease.—Gerhard Zbinden, M.D., in *Clinical Pharmacology and Therapeutics*, 5: 5, (Sept.-Oct.) 1964.

## PHYSICAL THERAPY LAW NOW IN EFFECT

It is of interest that in lieu of the Physical Therapists Practice Act of 1963 that no person may represent himself to be a Physical Therapist, Physiotherapist or use in connection with his name the words or letters "R.P.T.," "P.T." or any other letters, words or insignia indicating or implying that he is a registered physical therapist until he has graduated from an approved school of physical therapy and is licensed to practice physical therapy in Georgia. He shall not treat human ailments by physical therapy or otherwise, except under the prescription, supervision and directions of a person licensed to practice medicine and surgery. Copies of this Law and further information may be obtained from the Georgia Board of Physical Therapy, 224 State Capitol, Atlanta, Georgia 30301.

Don Hancock, Jr., R.P.T.  
President, Board of Physical Therapy

## "EXTREMISM" IN DRUG REGULATIONS?

Of great importance to the public at large, physicians and the drug industry is the increasingly heavy hand of restrictions being laid upon the pharmaceutical industry. The question is not a matter of whether certain rules and regulations ought to be followed in the testing and marketing of drugs, but how strict should they be. Or to put it another way—how "extreme" should such directives be—very mild and loose (ultra-right?) or very tight and restrictive (ultra-left?).—Joseph P. Schaefer, M.D., in *New Physician*, 13: 10, (Oct.) 1964.

## HYSTERIA—PANDEMONIUM— PRESSURE

Legislation that is conceived and enacted in an atmosphere of panic is usually ill-advised and may be disastrous. This statement applies to the passage of the Kefauver-Harris amendments to the Food, Drug and Cosmetic Act. It had its origin in the hysteria and panic of the thalidomide tragedy, it was nurtured and developed in the pandemonium of the biased hearings before the Kefauver Committee of the Senate, and through the pressure of an impetuous administration, was enacted into law.—John C. Krantz, Jr., Ph.D., in *Military Medicine*, 130: 1, (Jan.) 1965.

## WANTED—PHYSICIANS FOR DRUG RESEARCH

It is common knowledge that the pharmaceutical industry is faced with a significant issue in the shortage of qualified investigators. Drugs are becoming more and more complex and the use of the general doctor, without specific experience in clinical investigation, in testing drugs in his office in the midst of a busy practice is coming to an end. The need for training of physicians in the drug research field has reached a critical stage, and this problem must be met by the joint efforts of government, industry, and the scientific community.—Joseph F. Sadusk, Jr., M.D., in *Bulletin of the American College of Physicians*, 5:6, (Nov.-Dec.) 1964.

## "BUSINESS SIDE OF MEDICAL PRACTICE" AND MEDICAL UNITS 'PLANNING GUIDE' STILL AVAILABLE TO INTERESTED DOCTORS

Because of the overwhelming response to MAG's offer of the American Medical Association-Sears Roebuck Foundation, Inc. booklets offered free of charge to Georgia doctors, the Headquarters office has obtained more copies of each and is anxious to reach still more of those who might be interested.

Each booklet, constructed of heavy vellum stock, measures approximately 12" x 9" and contains charts, graphs, illustrations, floor plans, etc. Both are made for easy handling and make a nice addition to a doctor's office library.

Either or both, "The Business Side of Medical Practice," and the "Medical Units 'Planning Guide'" may be obtained by writing to the *Medical Association of Georgia*, 938 Peachtree St., N.E., Ga. Atlanta, 30309.

# ADAMANTINOMA OF THE TIBIA

Ernest G. Edwards, M.D., *Savannah*

■ This tumor has a marked similarity to a synovial sarcoma.

THE CASE to be presented concerns a most unusual type of tumor present in a 16-year-old white female and found adjacent to the medial aspect of the right upper tibia. The particular tumor to be described is of considerable interest chiefly because of its marked similarity to an adamantinoma often found within the bony substance of the tibia but in this case actually being adjacent to the tibia and not involving the bony substance, and also because of the rather marked similarity of this type tumor and a synovial sarcoma.

## Case Presentation

The patient is a 16-year-old white female who had noticed a swelling on the medial and upper

aspect of her right leg below the knee for about 1½ years before being seen. At times she described the swelling as being quite tender particularly after prolonged use of the leg; walking, standing, dancing, etc. The patient was first x-rayed by her physician in 1962. We first saw this patient approximately one year later, apparently the mass having grown little if any in size during this time.

Examination revealed a well developed 16-year-old white female. There was a firm mass measuring approximately 6½ centimeters in area over the medial and posterior aspect of the right upper tibia below the knee joint. The mass was slightly tender but was essentially non-movable.

The patient's x-rays were reviewed at this time



FIGURE 1



FIGURE 2





FIGURE 3

and these revealed a soft tissue mass adjacent to the medial aspect of the right upper tibia with some mottled adventitious calcification. Interpretation by the radiologist at that time was calcifying hematoma or possibly a chondro-sarcoma. No bony involvement could be discerned.

At this time new x-rays were made. These again revealed essentially the same picture as before with possibly some more diffuse calcification within the soft tissue mass. Biopsy was promptly advised and the patient was admitted to the hospital. Laboratory work upon admission to the hospital revealed a hemoglobin of 13 grams, hematocrit of 39 vol. % white blood count was 6,530, 68% segs. 28% lymphocytes, 2 monocytes, 2 eosinophiles; urine essentially negative.

### Surgery

On 2-25-63, in surgery, the tumor was explored. A medial incision was made over the upper right leg and after incision of the fascial planes of the leg, the tumor mass was encountered. It was approximately the size of a pear, well encapsulated, somewhat pink in color and did not appear to be excessively vascular, though somewhat cellular. As far as could be determined, after outlining the tumor mass, the capsule appeared to be somewhat intimately adherent to the intermuscular fascial septae and at one portion, in so far as could be determined, adherent to the periosteum of the tibia for about 1/2 inch. There was no direct attachment to the bone. Frozen sections were taken during surgery

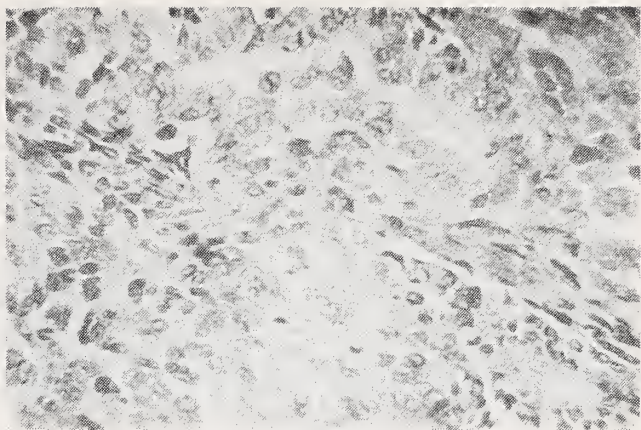


FIGURE 4

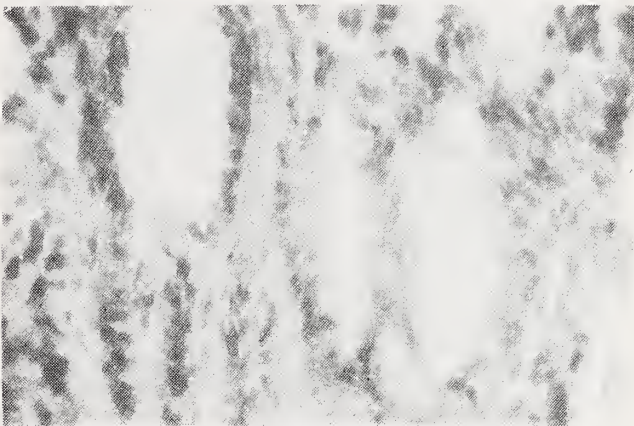


FIGURE 5

and these were described as essentially benign. The entire tumor mass was resected and the wound closed in the usual manner.

The patient's postoperative course was uneventful. The patient had additional x-rays made of the leg about four months after surgery. We did not see the patient again until April 30, 1964. New x-rays were made.

### Identification Difficult

From the pathological standpoint, the tumor has presented considerable difficulty in exact identification. Numerous sections have been made of the tumor mass by the pathologists and numerous pathologists have examined various aspects of this tumor. Originally the presentation was made to a group of four local pathologists who immediately identified the tumor as an adamantinoma. Since then there has been a further description and a marked similarity between this tumor and a synovial sarcoma.

### Conclusions

1—a most unusual type of tumor bearing a close and marked resemblance to an adamantinoma of the tibia yet lying without the bony substance of the tibia is presented.

2—The tumor mass was encapsulated and appeared to involve the periosteum of the tibia for a short extent but mostly the intermuscular fascial

septae. The marked similarity and differentiation between this particular tumor and a synovial sarcoma is described.

321 East Hall Street

#### BIBLIOGRAPHY

1. *Orthopedic Diseases*—Aegerter Kirkpatrick, 2nd Edition.
2. *Bone Tumors*, L. Lichtenstein, 1952.
3. Arthur Purdy Stout, M.D., College of Physicians and Surgeons, Columbia University, New York, N.Y. (Personal Communication).

4. Dr. L. Lichtenstein, Veterans' Administration Hospital, San Francisco 21, California (Personal Communication).

5. Dr. H. L. Jaffe, 1919 Madison Avenue, New York, N.Y. 35 (Personal Communication).

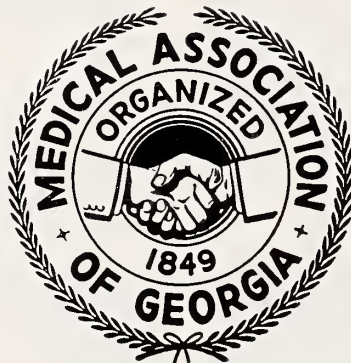
6. Dr. Lent Johnson, A.F.I.P., Washington, D.C. (Personal Communication).

7. *Atlas of Tumor Pathology*, A.F.I.P., Section 2, Fase. 4.

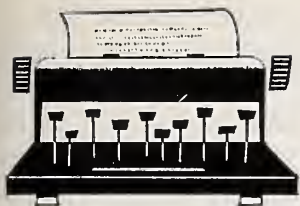
#### ACKNOWLEDGEMENTS

Dr. Carlos Jaramillo, Pathologist, Memorial Hospital, Chatham County, Savannah, Ga.

Dr. Fred Kessler, Savannah, Ga.







## Interstitial Pulmonary Edema

**L**ESIONS that initially place a work load on the left heart may produce congestion of the pulmonary vascular bed early in the course of heart failure. Examples are coronary disease, hypertension, aortic valve disease and mitral stenosis. Conventionally one thinks of signs and symptoms such as rales, dyspnea on exertion and paroxysmal nocturnal dyspnea in this setting. However, it is not widely recognized that there may be interstitial edema without rales, ventricular diastolic gallop rhythm, abnormal neck vein distention, dyspnea or even significant increase in pulse rate. Detection of interstitial pulmonary edema rests on the chest x-ray. Findings may be listed as follows:

1. Dilated superior pulmonary veins (above 10 mm. wedge pressure).
2. Increased interstitial density of lung (above 15-18 mg. Hg.).
  - a. Clouding of lungs.
  - b. Loss of sharp definition of vessels.
  - c. Septal lines (A & B Lines of Kerley)
  - d. Thickened fissures.
3. Dilated pulmonary arteries.
4. Pleural or subpleural effusion.

When the pulmonary venous pressure exceeds the oncotic pressure (about 25 mm. Hg.) alveolar edema occurs. Confluent areas of alveolar edema may simulate pneumonia, infarction or tumor. For

every case of alveolar edema, one may see 20-30 instances of interstitial edema. The initial clue may be ventricular diastolic gallop, rales or neck vein distention. Patients with acute myocardial infarction are likely to have interstitial edema:

1. With sinus tachycardia of 120 or greater.
2. Shock.
3. Ectopic arrhythmia lasting one hour or more such as atrial fibrillation or ventricular tachycardia.
4. With appearance of basal rales appearing on the dependent side.
5. When the neck veins are distended with the patient propped at an angle of 30-45°.
6. Usually but not invariably when there is a ventricular diastolic gallop rhythm.

A bedside film is usually but not always satisfactory. In any given film, the response of the changes to digitalization and diuresis when the film is repeated after several days may be necessary to clearly identify interstitial edema. Prompt recognition and treatment may improve recovery rates in myocardial infarction.

### REFERENCES

Logue, B.; Rogers, J.V., and Gay, B.B.: Subtle Roentgenographic Changes of Left Heart Failure, *Amer. H.J.* 65: 464-473, April, 1963.

Kerley, P. J.: Radiology in Heart Disease, *Brit. Med. Jour.* 2:594, 1933.

## "Medicare" — The Second Half of a Long Ball Game

**A** NEW CHAPTER in the long and sometimes bitter campaign for Social Security medical care for the aged was written last month by the lower House of the Congress. As everyone knows, the so-called "medicare" bill, grossly inflated beyond even the President's request, was adopted by a three-

to-one majority in the House. In retrospect perhaps, the outcome in the House was not wholly unexpected. To be sure, those who did little or nothing to prevent its passage will tell you that the outcome was never in doubt. In spite of the willingness of some to "throw in the towel" before the ball game

is over, this issue is a long way from being resolved completely. It must yet be approved (or rejected) by the Senate.

In the upper chamber, the Senate Committee on Finance will have primary jurisdiction and hearings on the bill were scheduled to begin in late April. A target date on which "medicare" will be called up for a vote on the Senate floor is uncertain. Such matters are handled entirely by the Senate majority leadership and it would seem fair to assume that it will be scheduled at a time when Administration forces can deliver their strongest vote. The proponents clearly hold most of the trump cards.

### Light Will Be Shed

Notwithstanding this, however, the Senate Finance Committee hearings on this legislation will shed considerable light on the far reaching and extremist proposals offered in the bill.

Unlike the Ways and Means Committee, which deliberated behind closed doors in the best tradition of a medieval star chamber proceeding, the Senate Finance Committee will hold open hearings so that the people and the press, as well as Members of Congress, may fully understand what they are being pressured to buy.

Following Committee action on the bill, it will be set down for a vote by the full Senate. Any

amendments made by the Senate must be agreed to by the House. Otherwise the bill will be sent to conference where the differences in the Senate and House versions must be ironed out. Should it become impossible for the Conference Committee to resolve the differences, deadlock results and no bill is adopted or sent to the White House for signature.

While a deadlocked conference is possible, it is not likely to happen. If the bill is to be defeated, then it must be done in Committee and on the floor of the Senate.

The legislative history of the bill up to this point has been a portrait in naked political power. Common sense, long standing obligations and the will of the people have all been shamelessly lost in the overzealous interpretations of the election returns of last November. Still, there is cause for hope; provided, of course, that hope is mixed well with political and legislative know-how and the two are blended with intelligent determination. The rule of reason is not completely dead, although it does appear to be in a trance, induced no doubt by blurred visions of the "Great Society."

One thing is clear—if the medical profession wants to win, then there is much work to be done and very little time in which to do it. If it has lost its taste for battle then most surely it has lost the supreme legislative battle of its long and honored history.

\* \* \*

Some 850,000,000 prescriptions were written in the United States during 1963.

\* \* \*

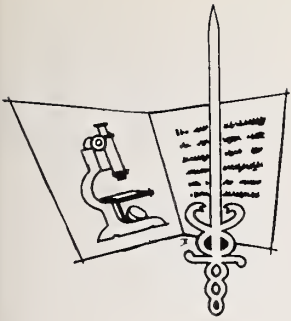
## OUR NEW DRUG RESEARCH DILEMMA

On one extreme is the opinion that any physician who is qualified to practice medicine is qualified to test new drugs. The wording of the (new FDA) regulations and testimony given at the hearings conducted by the late Senator Kefauver would seem to refute this. On the opposite pole we find two contending philosophies; one, that the physician who tests drugs in humans must be first of all a thoroughly-trained pharmacologist who then applies this knowledge and training to a study of drugs in man, or that he should be trained primarily in clinical medicine, for several years beyond the internship, during which time he will have carried out investigations on patients, some of which will have been studies on drugs. These are the two horns of the dilemma that are facing clinicians, investigators, medical educators and government officials today.—Harry F. Dowling, M.D., in *J.A.M.A.*, January 18, 1964.

## "THE BUSINESS OF DRUG TESTING"

Francis Boyer, chairman of the board of Smith, Kline and French Laboratories, in a special article . . . indicates additional hazards associated with the clinical testing of new drugs as a result of the 1962 amendments to the previously existing food and drug legislation. Not only is the physician thus engaged subjected to a greatly increased burden of paper work, but also to the so far unpredictable possibility of legal action, since the FDA certificate that he is required to submit states that his patients are being used for the purpose of investigating new drugs, with no indication that they may be benefited thereby. Certainly, a tangled web seems to have been woven in the effort to ensure that all drugs reaching the market are both reasonably safe and reasonably effective.—Editorial in *New England Journal of Medicine*, 270: 15, (April 9,) 1964.





## SKIN CANCER

David L. Hearin, M.D., *Atlanta*

**T**HE SKIN is a common site for malignant lesions, accounting for about 17% of all types of malignancy in men and about 11% of all forms in women. Skin cancers for the most part are easily diagnosed and readily treated with good results.

Being visible, these lesions should arouse concern in the patient earlier than other forms of malignancy. Patients, however, are prone to "wait until it bothers me." These lesions usually produce no discomfort and are slow growing.

### Surgical Excision

Surgical excision is a good form of therapy for all cutaneous malignant lesions and is the procedure of choice for malignant melanoma, regardless of location or size. Melanomas account for less than 1% of malignancy of all types.

Squamous cell epithelioma can be treated by surgical excision, x-ray therapy or coagulation and curettage, depending on location of the lesion as well as the size of the lesion.

Basal cell epithelioma is readily treated by electrocoagulation and curettage and is my procedure of choice if the lesion is less than 1 cm. in diameter. This method of treatment is excellent for lesions of the nose, ear and dorsum of the hand, where there is thin skin and little subcutaneous tissue.

Malignant lesions of the ear can be treated by electrocoagulation and curettage and by surgical excision, especially if the cartilage is already involved, and by x-ray therapy.

With basal cell lesions of the ear, electrocoagulation and curettage produces little discomfort during or after the procedure and gives good cosmetic results, especially in older patients. Squamous cell

lesions of the ear, if less than 1 cm. in diameter and if the cartilage is not involved, can also be treated by this method. If either of these criteria is exceeded, surgical excision is the procedure of choice. If x-ray for malignant lesions of the ear is used, the total dosage should be divided into frequent treatments of a lower dose than would usually be used on skin lesions elsewhere. Regardless of location, I feel that a total dose of at least 3500 R should be given for basal cell lesions, and 4500 R for squamous cell lesions. The skin reaction and discomfort are both reduced if the total dose is given in six to ten treatments in a 14 day period.

Since skin lesions are so easily seen and biopsied there is little reason to adopt a "wait and see" attitude, if you seriously consider a diagnosis of malignancy in any skin lesion. I cannot stress too strongly the fact that whoever does the initial treatment has the best chance to produce a cure, and whatever form of treatment is carried out must be adequate enough and extensive enough to produce a cure. Invariably, the lesions that are most troublesome and produce the greatest scar and the poorest results are those that were treated inadequately initially.

While electrocoagulation and curettage is a good form of treatment in my hands, it may not be when some other individual does not carry out this procedure adequately. Use a procedure or method of treatment that you feel certain is adequate in "your hands;" this gives much better chance for cure and this, of course, is the reason for treatment.

*3158 Maple Drive, N.E.*

Approved by the Professional Education Committee, Georgia Division, ACS.

## KNOWHOW IS KNOWHOW IS KNOWHOW

The pharmaceutical industry . . . has developed a great deal of knowhow in the preparation of drugs so as to insure the stability, purity and reliability of their products. The excellent work done by the Food and Drug Administration to insure purity in food and drugs has borne fruit and no sensible manufacturer would release imperfect or impure agents for use. Further-

more, manufacturing controls have become much more effective. The pharmaceutical industry can take great pride in its achievements in insuring that its products have the type of purity and stability needed for use in man.—Dale G. Friend, M.D., in *Journal of the American Pharmaceutical Association*, NS4: 11, (Nov.) 1964.



## PRESENT STATUS OF LONG TERM ANTICOAGULANT THERAPY IN CORONARY ARTERY DISEASE

Huddie L. Cheney, M.D., *Thomasville*

**A**NTICOAGULANT THERAPY in coronary artery disease has been in widespread use for nearly two decades. Even after this period of time there is still much confusion regarding the place of the anticoagulants in this disease.

Although not everyone agrees with the use of anticoagulants in acute myocardial infarction, this form of treatment has gained widespread acceptance throughout the world and today the vast majority of patients who have an acute myocardial infarction receive anticoagulant therapy if no contraindications are present.

### Long Term Coagulation

Most of the confusion centers around the efficacy of long term anticoagulation. In which patient should the drugs be given over a long period and for how long should they be used? There have been a considerable number of studies done attempting to arrive at these answers. The results and conclusions drawn have been conflicting. One group has found that under age 60, anticoagulants have significantly reduced re-infarction, mortality and morbidity during the first year following the initial infarction. Benefit has been less significant in the old age group and also after the first year. Several other studies have drawn essentially the same conclusions. However, one recent study found no significant improvement with long term therapy. When these findings were weighed against the risk of hemorrhage, the psychological, social and economic problems presented by this form of treatment, the long term use of anticoagulants were not recommended as routine treatment in coronary heart disease.

Even though most of the workers in the field recommend some form of long term treatment, there is considerable disagreement regarding the length

of time therapy is beneficial. Should it be for one month, three months, one year, two years or life? Most of the data supports the concept of benefit for the first year after myocardial infarction. This is a controversial point and certainly no answer has been universally accepted. A great number of physicians stop the patient's anticoagulants after the first month and there is also a considerable number of patients who are kept on these drugs indefinitely with a projected life-time therapy.

### Who Is To Receive

Another controversial point is which patients should receive the anticoagulants. Certain contraindications are generally accepted by most physicians. These are—

1. Inability of patient to follow instructions.
2. Inaccessibility of adequate lab facilities.
3. Undue economic strain.
4. Certain complicating diseases such as severe hypertension.

If none of the above are present the consensus of opinion is that the younger patients should receive long term therapy.

If the above discussion seems confusing it is because the current status of long term anticoagulants in coronary artery disease is one of confusion. Obviously more studies are needed over a longer period of time so that eventually the true value and subsequent place of long term anticoagulation can be established. Until then each physician must decide from the conflicting reports how to use anticoagulant drugs in treating patients with coronary artery disease.

*209 Mimosa Drive*

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.



**ANNUAL LEGAL CHECK UP**William B. Spann, Jr., *Atlanta*

**A**LL PHYSICIANS will be familiar with the annual physical examination of their patients. Are members of The Medical Association of Georgia familiar enough with the comparable need of physicians for the "annual personal legal check up?" The undersigned recently attended the excellent National Medicolegal Symposium jointly sponsored by the American Medical Association and the American Bar Association at Las Vegas, Nevada. A considerable portion of the time of the program was spent on preparing lawyers present on how to deal with the annual legal check up of physicians. It was observed that the physicians present seemed as interested in the topic as the lawyers.

The outline for the annual legal check up is sufficiently interesting to set out in full:

**SPECIAL ANNUAL CHECK LIST**

## Reviewing Physician's Personal Status

(Indicate change  
by Yes or No)**I. Change in Family Situation**

- a. Birth or death of children, grandchildren; adoption \_\_\_\_\_
- b. Death of parent, brother, sister \_\_\_\_\_
- c. Death, divorce or separation of spouse \_\_\_\_\_
- d. Children entering college \_\_\_\_\_
- e. Children marrying \_\_\_\_\_
- f. Children who became self-supporting \_\_\_\_\_
- g. Marriage and any antenuptial agreement \_\_\_\_\_

**II. Income Status**

- a. Change in level \_\_\_\_\_
- b. Capital gains problems (sales) \_\_\_\_\_
- c. Tax returns delinquent \_\_\_\_\_
- d. Gifts made or to be made \_\_\_\_\_
- e. Charitable donations (other than nominal) including pledges for more than 1 year \_\_\_\_\_

- f. Have you inherited any property or received any gifts? \_\_\_\_\_
- g. Audit of tax returns or net worth \_\_\_\_\_

**III. Real Property**

- a. Purchase or sale of home \_\_\_\_\_
- b. Purchase or sale of any other realty \_\_\_\_\_
- c. Leases—new, renewal \_\_\_\_\_
- d. Change in zoning, use, local planning \_\_\_\_\_
- e. Mortgage retirement, reduction or increase \_\_\_\_\_
- f. Possibility of refinancing any loans \_\_\_\_\_
- g. Transfer of ownership to spouse; children \_\_\_\_\_
- h. Option to purchase land \_\_\_\_\_

**IV. Personal Property**

- a. Investment portfolio—value changed? \_\_\_\_\_
- b. Sales, purchases, gifts \_\_\_\_\_

**V. Insurance: Policies matured, renewed, converted, dropped**

- a. Life \_\_\_\_\_
- b. Health and accident \_\_\_\_\_
- c. Automobile \_\_\_\_\_
- d. Liability (other than malpractice) \_\_\_\_\_
- e. Fire, theft, homeowners, etc. \_\_\_\_\_
- f. Time loss \_\_\_\_\_

**VI. Your Estate Plan**

- a. Do any changes in above indicate need for re-planning? \_\_\_\_\_
- b. Does the personal health situation of yourself or any family member indicate a need for change in plan? \_\_\_\_\_
- c. Is a new will needed because of changes in personal affairs or by changes in law? \_\_\_\_\_
- d. Do you or wife have power of appointment in any will? \_\_\_\_\_

VII. *Personal Affairs*

- a. Any accidents, losses, pending claims or lawsuits? \_\_\_\_\_
- b. Change in location of home, practice, office, etc.? \_\_\_\_\_
- c. Add or drop any home employees? (Soc. Sec., ins., etc.) \_\_\_\_\_
- d. Driver's license—any traffic convictions during year? \_\_\_\_\_
- e. Have you signed a note or assumed a liability for anyone else? \_\_\_\_\_
- f. Are you facing contingent liability from malpractice, a car accident or other cause which may exceed your insurance limits, and thus be a claim against your general assets? \_\_\_\_\_

VIII. *Business (Professional)*

- a. Change in status, partnership, etc.? \_\_\_\_\_
- b. Retirement program and insurance plan changes \_\_\_\_\_

- c. Changes in hired personnel (office) \_\_\_\_\_
- d. Significant trend of practice: change in net income, bad debts, ownership of building, etc. \_\_\_\_\_
- e. Sale of practice or of partnership interest contemplated, under negotiation, or completed? \_\_\_\_\_

A "YES" answer above indicates need for review of status with your attorney.

It is respectfully suggested that readers of this Legal Page fill out the form. If you answer "Yes" in any one or more of the categories, it would be wise for you to consider consultation with your attorney. An annual check up with your own attorney is wise even if you do not recognize the importance of any of the particular items because he may well know special items about your circumstance which would indicate regular check up.\*

\*The form above quoted was prepared and presented at the National Medicolegal Symposium on March 12, 1965, by Philip S. Habermann, Esq., Executive Director, State Bar of Wisconsin.

Prepared at the request of The Medical Association of Georgia. Mr. Spann is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

HOW TO INSURE PATIENTS' HEALTH AND SOLVENCY

This relationship of drug manufacturers, government, and individual investigators is a difficult one. I strongly believe that all of us must want to make it a workable and fair one. It is time the FDA quit acting as policemen too ready to hand out a ticket and for manufacturers to be on their guard against overstepping reasonable bounds in their desire to promote a product. We physicians should make every effort through the American Medical Association and the physiological, clinical, and pharmacological societies to express considered points of view and help keep the peace as well. Our patient's good health and his solvency are at stake. —Irvine H. Page, M.D., in *Modern Medicine*, 32:25, (Dec.) 1964.

STOLEN DRUGS AT BARGAIN PRICES

Recently a major American pharmaceutical firm was successful in suing a former employee for selling secrets of research and production of an antibiotic to an Italian drug manufacturer—however, not until long after the Italian firm, whose research and development cost had thus been paid by the American competitor, had underbid the same firm in a large sale of this drug back to the United States government. . . . Vigorous protests by many persons and organizations are now being made against purchases by our government of foreign drugs produced on the basis of formulae and methods stolen from ethical American manufacturers. —Editorial, in *Rocky Mountain Medical Journal*, 61: 10, (Oct.) 1964.

MOTIVATION FOR NEW DRUG RESEARCH

The purpose of drug investigation is to acquire and interpret reliable data which may either lead to practical medical conclusions about new therapeutic agents, or bring about a better understanding of the body systems and the ways in which disease affects them. The object is not to placate or please, to avoid controversy, or shun possible lawsuits, but to gain knowledge in the interest of mankind. Acquisition of new knowledge, the finding of new cures, and the solving of some of the more stubborn mysteries in the health field, are what motivate the drug researcher. —Austin Smith, M.D., in *Experimental Medicine and Surgery*, 22: 2-3, (June/Sept.) 1964.

NO SUBSTITUTE FOR CLINICIAN'S JUDGMENT

The new food and drug laws and regulations of 1962 are aimed at improving the safety of new compounds. Although compliance may minimize the risk, they must not be permitted to interfere with research, since maximum usefulness and safety still depend in most instances on knowledge not yet available. If we are to progress toward the discoveries which may lead to the control or elimination of mankind's remaining maladies, some calculated risks must be taken. To this end there is no substitute for the judgment of the clinician particularly in that most important step—from experimental animal to the first use in man. The university scientist's role in drug investigation is an essential component in this most important objective. —L. T. Coggeshall, M.D., Vice President, University of Chicago, in *Southern Medical Bulletin*, December, 1963.





## THE ROLE OF THE MEDICAL SCHOOL IN COMMUNITY MENTAL HEALTH PROGRAMS

E. James McCranie, M.D.,\* *Augusta*

THE PARTICIPATION of the medical school in psychiatric training is one of the newer developments in medical education. The Flexner report of 1910 barely mentioned psychiatric teaching. In 1912 the total teaching requirement for psychiatry, as dictated by the American Association of Medical Colleges, was a mere 20 hours. During the next 20 years progress was slow. However, since World War II psychiatry has grown rapidly from a minor to a major role in the medical school curriculum. At the present time psychiatry has achieved the status of a major department in most medical schools. Along with the development of undergraduate psychiatry there has been a shift of specialty training in psychiatry from the state hospital to the medical school center.

### Part of General Trend

The growth of psychiatry in the medical school has been a part of a general trend. Throughout the 19th century and most of the first half of the 20th century, the practice of psychiatry in the United States was practically synonymous with institutional psychiatry. However, in the past several years, along with the development of academic psychiatry, there has been an equally marked increase in the private practice of psychiatry and a proliferation of a variety of community clinics. These developments have demonstrated that most patients with mental illness can be treated in the local community and that hospitalization, when necessary, cannot only be greatly shortened but can and should be used as a minor phase of a more comprehensive rehabilitation program. A widespread application of this new approach is the basic concept behind the current push for the development of comprehensive community mental health programs.

The function of a medical school is usually considered under the three categories of training, research, and service. The medical school can play

a critical role in all three areas in the emerging development of community mental health programs.

At the present time, the most crucial problem is the training of mental health personnel. Since the primary function of the medical school probably still is the education of physicians, the logical contribution of the medical school is the training of psychiatrists and the psychiatric orientation of other physicians. The latter needs to be done on two levels: in the undergraduate medical curriculum and in postgraduate education for physicians already in practice.

### Considerable Progress

As has been indicated, there has been considerable progress in the past several years in introducing psychiatry into the undergraduate medical curriculum and in the development of psychiatric residency programs in medical school centers. However, much remains to be done. Both the size and quality of residency programs need to be increased. There is also considerable room for improvement in the undergraduate teaching of psychiatry. If we are to get the future physician involved in mental health programs in his community, we must offer him clinical experience in similar programs in his medical school curriculum. Consequently, a very urgent need is the development of comprehensive mental health centers in connection with medical schools. Such centers would not only be helpful in training medical students but would also provide better training facilities for residents, general physicians, and other mental health professions.

### Postgraduate Psychiatric Education

As to postgraduate psychiatric education, there is a great deal of talk and activity going on. So far, I think we have raised more problems than we have solved. To my mind, one of the most important problems is the fact that the average physician has succeeded in evading any real responsibility for understanding or treating psychiatric problems. The

\*Chairman and Professor, Department of Psychiatry and Neurology, Eugene Talmadge Memorial Hospital and the Medical College of Georgia.

first step is the education of the medical profession to its responsibility in this area. As this is done, the physician will take more initiative in demanding the type of postgraduate psychiatric education that will be relevant to his needs. The psychiatric profession, both in and out of medical schools, is concerned about its obligation and aware of its shortcomings and inexperience in formulating and communicating its knowledge in ways that are meaningful to the general physician. We are working on these problems. But we cannot succeed unless there are students who want to learn, who feel a responsibility for the

care of the type of problem in which psychiatric knowledge would be useful.

Another important function of the medical school is research. In addition to basic research, the medical school should assume considerable responsibility in improving techniques of applying basic knowledge to the solution of practical clinical problems. The association of a comprehensive mental health center with a medical school would provide an ideal laboratory for applied research. It could provide a facility for rigorous testing of present concepts of community care as well as searching for new techniques and approaches to mental health problems.

*Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.*

## ABSTRACTS BY GEORGIA AUTHORS

**Humphries, Arthur L., Jr., M.D.; William S. Corley, M.D.; and William H. Moretz, M.D., Medical College of Georgia, Augusta, Georgia, "Massive Closure Versus Layer Closure for Abdominal Incisions," Am. Surg. 30:700-705 (Nov)64.**

We have tried a massive closure for many incisions thought prone to dehiscence. This paper compares massive closures with layer closures for 1,596 abdominal incisions.

The massive closure usually consisted of figure-of-eight sutures of No. 1 Nylon, wire or silk placed well back (2.5 cm.) from the wound edge to encompass all layers of fascia and muscle, as well as peritoneum. In addition, it usually included interrupted sutures of finer materials, such as No. 20 cotton in the anterior sheath (or linea alba).

Twenty-two (1.4%) of 1,596 incisions dehiscence. Twenty-one of these were in patients over 50 years old.

Results among 581 patients over 50 years old who had vertical incisions (374 males and 207 females):

Nineteen of the 22 dehiscences occurred in this group of patients. Eighteen of the 19 were in males.

With the massive closure, eight (3.0%) of 267 vertical incisions dehiscence, and with the layer closure 11 (3.5%) of 314. Although the massive closure does not appear clearly superior by these figures alone, it appears more so after determining its use in a disproportionately high number of patients with conditions expected to impair wound healing.

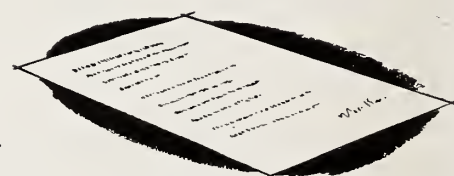
**Morgan, Anne D., M.D.; Dorothy Brinsfield, M.D.; and F. Kathy Edwards, M.D., 69 Butler Street, S.E., Atlanta 3, Georgia, "Persistent Truncus Arteriosus," Am. J. Dis. Child. 109:74-79 (Jan) 65.**

As isolated malformations, persistent truncus arteriosus and atresia of the aortic arch are unusual cardiovascular anomalies. The presence of both conditions in an individual has been reported in only two previous cases in the recent literature. In the case presented the diagnosis of persistent truncus arteriosus was suggested by the typical physical findings: mild arterial desaturation (83%), a systolic murmur extending into diastole, a loud single-second sound, peripheral signs of aortic run-off, and congestive failure. Postero-anterior roentgenograms showed generalized cardiomegaly and pulmonary plethora. The electrocardiogram at four days of age showed tall peaked P waves, a qR with upright T waves in V R and increased voltage in the mid and left precordial leads. This was interpreted as biventricular hypertrophy. The Frank vectorcardiogram showed clockwise rotation of the frontal QRS loop, which had a markedly posterior rotation, and increased anterior and posterior voltage in the horizontal plane. Selective angiocardiology demonstrated the complete atresia of the aortic arch distal to the left subclavian artery. The clinical impression of persistent truncus arteriosus, insufficiency of the truncal valve, and ventricular septal defect were confirmed by cardiac

catheterization and angiocardiology. Although the diagnosis of this combination of anomalies can be made prior to death, no surgical treatment is presently available for this condition.

**Ellison, Robert G., M.D.; Albert W. Bailey, M.D.; Thomas J. Yeh, M.D.; Raymond F. Corpe, M.D.; Joseph Liang, M.D.; and Ingrid Stergus, M.D., Medical College of Georgia, Augusta, Georgia, "Primary Lymphosarcoma of the Lung," Am. Surg. 30:737-744 (Nov) 64.**

Lymphosarcoma arising in the lymphatics of the lung is being recognized with increasing frequency. Characteristically these neoplasms arise within the parenchyma of the lung and may present as isolated nodules or may attain bulky proportions before the onset of symptoms. The natural history of the tumor is one of slow growth with late involvement of regional lymph nodes. Review of the literature revealed 65 cases previously reported and four additional cases were reported in this paper. Of these 69 cases most were diagnosed during the fifth or sixth decades. Twenty-five per cent were asymptomatic. Fifty per cent had bronchopulmonary symptoms, such as coughs, sputum, hemoptysis. Vague constitutional symptoms were prevalent. Of the four cases presented one died six years after surgery of recurrent disease and three are alive at five, eight and 11 years. The four cases reported here represent the largest single series of five-year survivors reported and supports other reports that this neoplasm





is of low-grade malignancy. With an aggressive attitude toward surgical exploration of undiagnosed, asymptomatic abnormal intrathoracic shadows, early detection of this neoplasm with long term survival can be anticipated.

**Converse, Peirce E., II, M.D., Atlanta, Georgia, "Potassium Reversion of Hypothermic Ventricular Fibrillation," J. Thoracic & Cardio. Surg. 48:996-1006(Dec)64.**

Perfusion hypothermia is now quite widely used for clinical open-heart surgery. Ventricular fibrillation is so frequently a complication that it must be dealt with as a routine problem. Although electric shock appears to be a generally satisfactory means of producing reversion, studies with potassium at low temperature have shown that this ion is very efficacious in producing reversion also. The ready availability of potassium is a distinct advantage and knowledge of its use may occasionally be life saving.

The only absolute requirement in effecting reversion from ventricular fibrillation in hypothermia is a period of complete cardiac standstill, either spontaneous or induced, at a time when the heart is capable of contracting in a coordinated fashion. Favorable factors for reversion are (1) vigorous fibrillation, (2) uniform myocardial oxygenation, (3) absence of cardiac dilation, (4) absence of severe regional thermal or chemical gradients, and (5) reasonable levels of potassium, calcium, and sodium. However, wide variations in pH, temperature, oxygenation, blood pressure, rate of perfusion, and absolute levels of potassium, glucose, sodium, and calcium are compatible with reversion.

Potassium citrate injected directly into the perfusion line or into the aortic root is effective in producing reversion. High transitory levels of potassium are readily obtained and those produce arrest. Return to strong myocardial contractions generally requires several minutes and may be quite delayed without the administration of ionized calcium. Myocardial function, as measured by post-revision cardiac output, does not appear to be deleteriously affected. This method is effective in both open- and closed-chest animal preparations and has been used clinically.

**Sato, Tsuneharu, M.D., and Robert B. Greenblatt, M.D., Medical College of Georgia, Augusta, Georgia, "Detection of Early Pregnancy," Am. J. Obst. and Gynec. 91:31-36(Jan)65.**

One hundred urine specimens from 61 women suspected of pregnancy and not more than ten days overdue were subjected to two rapid immunological tests and the rat ovarian hyperemia test for comparative purposes. The index of accuracy was 87.5% for the two hour hemagglutination inhibition test, 40.6% for the slide latex particles test and 65.6% for the rat ovarian hyperemia test. The hemagglutination and rat tests gave one false positive result, but none were obtained with the slide latex test. After the thirteenth or fourteenth day, the reliability of both immunologic and rat ovarian hyperemia

tests progressively increased, and each reached a degree of accuracy greater than 95%.

**Ellison, Lois T., M.D., and Robert G. Ellison, M.D., Medical College of Georgia, Augusta, Georgia, "Surgery of Bullae, Blebs, and Cysts of the Lung," Am. Surg. 30:774-779(Nov)64.**

Forty-one patients admitted for surgical evaluation of bullae, blebs, and cysts of the lung during a six-year period are reported.

Pulmonary resection was performed in 22 patients, five having bilateral surgery. Pulmonary function studies are presented in 16 of these cases. Good results were observed in 17 of the 18 adults and in two of the four children.

Closed thoracotomy was the only treatment in six cases. Parietal pleurectomy was carried out in six instances, bilateral in three while no operation was recommended in seven patients.

Usually surgical treatment is not helpful when advanced generalized obstructive pulmonary disease exists. Hypoxia and severe dyspnea, however, may result from mechanical compression of lung and are not necessarily contraindications. On the other hand, carbon dioxide retention is almost certain evidence that the disease is too diffuse for an operation to be beneficial.

By careful selection of cases, skillful management of anesthesia and expert postoperative care, surgical excision of compressing air space abnormalities can produce long-term worthwhile improvement.

**Engler, Harold S., M.D.; Alberto A. Zavaleta, M.D.; and William H. Moretz, M.D., Medical College of Georgia, Augusta, "Hemobilia," Am. Surg. 30:756-755 (Nov) 64.**

Hemobilia denotes bleeding through the biliary ducts with or without bile. The bleeding may be profuse and exsanguinating. This report presents briefly the causes, manifestations, and diagnosis of hemobilia, and discusses in more detail hemobilia resulting from trauma, known as traumatic hemobilia. Two patients with hemobilia following trauma are presented and the pathology, clinical behavior, prognosis and management of traumatic hemobilia are considered.

The diagnosis should always be considered when gastrointestinal bleeding follows abdominal injury. At exploration, if the diagnosis is suspected it is substantiated by demonstrating blood in the biliary tract.

Signs and symptoms are related to distention and obstruction of the biliary tract and to bleeding. Periodic episodes of colicky, right upper quadrant, abdominal pain, associated with melena and hematemesis are characteristic. Mild jaundice and fever are common.

The high mortality associated with the typical periodic hemorrhages require an aggressive surgical approach. Ligation of an hepatic artery, drainage with packing of the liver cavity and removal of the affected part of the liver by partial or complete lobectomy are recommended procedures in appropriate circumstances.

**Harrison, J. Harold, M.D., and Antonio R. Perez, M.D., 490 Peachtree**

**Street, N.E., Atlanta, Georgia, "Advanced Ischemia," Arch. Surg. 89: 817-826 (Nov) 64.**

Direct surgery of the femoral, popliteal and tibial arteries was employed in 216 extremities of 206 patients with advanced ischemia, 101 of these facing immediate amputation. Surgery extended distally to the terminal popliteal, tibial, or peroneal arteries in 50% of the patients. Follow-up was from six months to six years, or an average of two years.

Arterial flow was restored by thromboendarterectomy or saphenous vein bypass grafts. Utilizing vein patch reconstruction, it was technically feasible to extend surgery to the tibial and peroneal arteries to the mid-third of the lower legs.

The overall success rate was 82.9%, while the salvage rate in extremities facing immediate amputation was 72.3%.

The degree of improvement and number of late failures were dependent upon the extent of disease, particularly in the lower leg vessels. Limited restoration of arterial flow was often inadequate to halt gangrene, heal ulcers and preserve a useful extremity.

The results indicate that arteriography and surgical exploration of the vessels are indicated in all extremities with hope of viability in otherwise operable patients before resorting to amputation.

**Logan, William D., Jr., M.D.; Federico C. Rohde, M.D.; Osler A. Abbott, M.D.; and Harold D. Meltzer, M.D., Emory University Hospital, Atlanta 22, Georgia, "Multiple Pulmonary Fibroleiomyomatous Hamartomas," Am. Rev. Res. Dis. 91:101-103 (Jan) 65.**

Pulmonary fibroleiomyomatous hamartomas are uncommon lesions. Most reported cases have had localized, solitary lesions. There have been some cases of diffuse fibroleiomyomatous lesions described. A review of the literature revealed two previously reported cases of multiple nodular fibroleiomyomatous hamartomas.

These lesions are benign lung tumors and occur less frequently than the chondromatous hamartomas. They may be confused with fibrosarcoma of the lung.

A case of bilateral multiple fibroleiomyomatous hamartoma is reported. Unusual circumstances presented the opportunity to excise these multiple lesions bilaterally, thereby providing the diagnosis antemortem.

**Hall, David P., M.D., and Robert G. Ellison, M.D., Medical College of Georgia, Augusta, Georgia, "Osteochondrosarcoma of the Chest Wall in a Newborn Infant," Am. Surg. 30:745-747 (Nov) 64.**

A case report of the successful removal of a malignant lesion from the chest wall of a newborn infant is presented to re-emphasize that radical surgical removal is not always futile. This was a primary osteochondrosarcoma and is unique in that its onset apparently occurred in fetal life. Six years after removal there is no evidence of recurrence. Reconstruction and function of the thoracic cage presented no problem.



## ABSTRACTS / Continued

Edmundson, H.T., M.D.; W. D. Jennings, Jr., M.D.; and C. Martin Rhode, M.D., Medical College of Georgia, Augusta, Georgia, "Pneumoperitoneum—A Rare Sign of Urinary Bladder Rupture," *Am. Surg.* 30:721-724 (Nov) 64.

Three patients were treated at the Medical College of Georgia Teaching Hospitals, Augusta, Georgia, with intraperitoneal rupture of the urinary bladder, secondary to blunt abdominal trauma. All three clinically had peritonitis and demonstrated free intraperitoneal air upon abdominal and chest x-ray studies. The pre-operative diagnosis in each was probable gastrointestinal tract perforation or rupture, but at exploration only the bladder was found to be ruptured; the gastrointestinal tract was intact.

The unusual feature of these cases was the free intraperitoneal air. How does the free air get into the peritoneal cavity? All had been catheterized. In one, the free air appeared only after catheterization, since prior abdominal x-ray showed no free air. No air had been purposely instilled into the bladder but some might have been introduced during the technique or irrigation. Room air might be sucked into the bladder through the catheter during the time the free exterior end is open. It is presumed that this suction is caused by negative intra-abdominal pressure during prolonged expiration, first pulling room air into the bladder and then through the bladder perforation into the peritoneal cavity. It must be emphasized, however, that these are speculative comments.

It is concluded that in certain cases of blunt abdominal trauma one may consider urinary bladder rupture, but should not be misled by free air within the peritoneal cavity. This is particularly true when there is a history of the patient having been catheterized after the injury and before x-ray examinations are obtained.

Sorsdahl, Oliver A., M.D. and Brit B. Gay, Jr., M.D., 1405 Clifton Road, N.E., Atlanta, Georgia, "Achalasia of the Esophagus in Childhood," *Dis. of Children* 109:141-146 (Feb) 65.

Three cases of achalasia in childhood with typical clinical and roentgenographic features are presented.

The onset of symptoms during childhood occurs in only 5% of patients with achalasia. Symptoms include regurgitation, obstruction to swallowing, and failure of growth and development. Ingested food found on the child's pillow, a choking sensation in the throat, and pulmonary symptoms also frequently occur.

Early in the disease, the major roentgenologic finding is disordered peristalsis when contrast material is ingested. Later, esophageal dilation with distal narrowing and poor peristalsis become evident.

The differential diagnosis includes congenital stricture of the esophagus and stricture secondary to hiatus hernia.

Stone, H. Harlan, M.D.; J. D. Martin, Jr., M.D.; William E. Huger, M.D.; and

Laura Kolb, B.S., 69 Butler Street S.E., Atlanta, Georgia, "Gentamicin Sulfate in the Treatment of Pseudomonas Sepsis in Burns," *Surg. Gynec. & Obst.* 120:351-352 (Feb) 65.

A new antibiotic, Gentamicin sulfate (Schering), was used in the treatment of 13 burned patients with *Pseudomonas* sepsis. Verdoglobinuria was present in all.

The infection was controlled in 12, and there were but 3 deaths. Drug toxicity did not occur.

Despite possible toxicity to kidney and vestibular nerve, judicious administration of the antibiotic has produced consistently good results in otherwise hopeless situations.

Stone, H. Harlan, M.D. and Iver C. Neilson, M.D., 69 Butler Street S.E., Atlanta, Georgia, "Hemangioma of the Liver in the Newborn," *Arch. Surg.* 90:319-322 (Feb) 65.

The eighth case of hemangioma of the liver in the newborn is reported. Duodenal stenosis and partial small bowel obstruction were additional problems that complicated surgery at the time of hepatic lobectomy.

The most reliable diagnostic findings are a palpable mass in the abdomen and signs which suggest intraperitoneal bleeding. Resection is indicated in order to prevent or control the intraperitoneal hemorrhage that results from rupture.

Hepatic lobectomy in the infant is feasible and is associated with no permanent derangement of liver function.

Cottrell, Hugh B., M.D., 50 7th Street N.E., Atlanta 23, Georgia, "Medical Preparedness for an Impending Disaster," *South M.J.* 58:250-254 (Feb) 65.

A time bomb was planted in the Mississippi River near Natchez due to the sinking of a barge containing 2,200,000 pounds of liquefied chlorine. This is more gas than was used during all of World War I.

Chlorine reacts with water to form hydrochloric acid. A tiny hole in a chlorine tank submerged in water would soon become a major rupture because of chemical reaction. The chlorine had to be removed before this happened. The U.S. Public Health Service was given the primary responsibility for protection of the public health.

In 1962, Federal, State, and local agencies were mobilized to afford the maximum possible protection to the 80,000 residents in the 30 mile danger zone. This undertaking was an unprecedented effort and is probably the largest emergency medical program of its kind. Treatment centers for chlorine gas poisoning were established, 132 shelters were set up in support areas, hospitals submitted a daily census of excess bed capacity, registration centers were established, the populous was informed of the possible effects and treatment of chlorine gas, evacuation routes and transportation for evacuees were arranged, gas masks and collective protectors were issued, an aid station was maintained at the barge site as the U.S. Corps of Engineers painstakingly removed the lethal tanks.

The experience gained during this two-month project undoubtedly pro-

vided all personnel involved with invaluable training in handling major disasters.

Stone, H. Harlan, M.D.; W. D. Jordan, M.D.; James J. Acker, M.D.; and J. D. Martin, Jr., M.D., 69 Butler Street S.E., Atlanta, Georgia, "Partial Arteriovenous Fistulas," *Am. J. Surg.* 109:191-196 (Feb) 65.

A review and the reported case revealed 37 documented A.V. fistulas involving the portal circulation. Half were of the splenic vessels. Trauma and spontaneous rupture of a prior aneurysm were the major etiologic factors.

Symptoms in the acute phase consist of abdominal pain, diarrhea, and gastrointestinal hemorrhage from congestive enteritis. After a quiescent period of two to five years, bleeding esophageal varices and splenomegaly developed secondary to prolonged portal hypertension. Larger fistulas were evidenced by a bruit or thrill. However, angiography proved to be the only reliable diagnostic procedure.

The overall mortality was 26%, although none survived without palliative or curative surgery. Exsanguination was the cause of the majority of deaths.

Exarhos, Nicholas, M.D.; William D. Logan, Jr., M.D.; Osler A. Abbott, M.D.; and Charles R. Hatcher, Jr., M.D., Emory Hospital, Atlanta 22, Georgia, "The Importance of pH and Volume in Tracheobronchial Aspiration," *Dis. Chest* 47:167-169 (Feb) 65.

Experimental tracheobronchial aspiration was studied in a series of 71 dogs utilizing different solutions: diluted hydrochloric acid, dog bile or ox bile, water, sodium lactate solution and isotonic saline solution, varying in pH from 1.36-5.67, and varying also in volume from 0.5 cc/kg-4cc/kg.

This study revealed two primary problems relating to aspiration. One is that of hemorrhagic tracheobronchitis and pulmonary edema which develops shortly after aspiration. The lower the pH and the larger the volume the more severe was the reaction. Although the pH of the bile, water, sodium lactate and saline solution was approximately the same, bile caused hemorrhagic pneumonitis when large volumes were used. Also, there was a production of brownish foam which contributed to the death of some of the animals because of the mechanical obstruction in the tracheobronchial tree.

The second problem is that of sudden apnea and hypotension following aspiration after the use of all solutions, except isotonic saline. The reaction was directly proportional to the acidity and volume of the aspirated solution. The suddenness of this reaction suggested a neurogenic etiology. Atropine in large doses did not block this reaction but bilateral vagotomy did.

The best therapeutic results were obtained by a combination of tracheobronchial lavage with assisted respiration, and systemically administered steroids. Attempted neutralization of low pH aspirants (HCL) with bile, sodium lactate and sodium bicarbonate did not alter the usual reaction.





# THE ASSOCIATION

## DEATHS

Ex-Atlantan, WILLIAM A. HODGES, SR., 80, of Lakeland, Florida, died March 18, 1965, at Lakeland. He recently received a 50-year pin from the Medical Association of Georgia.

Dr. Hodges was also a member of the American Medical Association and the Fulton County Medical Society. A 1913 graduate of Emory Medical College, he was a 32nd degree Mason and a member of the Shrine.

He moved to Lakeland three years ago.

Survivors are his widow, Hattie Jane Hodges; a son, Dr. William A. Hodges, Jr., both of Lakeland; a sister, Mrs. Lula B. Malone of Atlanta, and four grandchildren.

SYLVESTER CAIN, 62, of Norcross, died February 28, 1965, at his home after a lingering illness.

A 1925 graduate of Emory Medical School, Dr. Cain interned at Grady Hospital, practicing for a few years in Plains and in Greenville, S.C. The rest of his career was devoted to his townspeople.

He was a member of the Chattahoochee Medical Society, the 9th District Medical Society, Theta Kappa Psi Medical Fraternity, and the Bank of Norcross board of directors.

Survivors include his widow, Mrs. Eugenia Hooper Cain; daughter, and son-in-law, Mr. and Mrs. Norman Arey; sister and brother-in-law, Mr. and Mrs. George Verner.

## SOCIETIES

The regular monthly meeting of the DOUGHERTY COUNTY MEDICAL SOCIETY was held February 25, 1965, in Albany. Following the buffet dinner, Samuel Raines, M.D., Professor of Urologic Surgery, University of Tennessee, Memphis, spoke on carcinoma of the prostate.

Rudolph Kaelbling, Assistant Professor of Psychiatry at Ohio State University, was a recent guest speaker at the meeting of the BALDWIN COUNTY MEDICAL SOCIETY, Milledgeville. His subject was "The Physiology and Pathology of Sleep and Sedation."

## PERSONALS

### First District

JULIAN K. QUATTLEBAUM, JR. of Savannah has been appointed a member of the Georgia State Board of Health by Governor Carl E. Sanders. Dr. Quattlebaum will succeed his father, J. K. QUATTLEBAUM, SR. who recently resigned from the Board.

### Second District

H. G. DAVIS, JR., Sylvester physician and surgeon, recently received an invitation to be one of a group of 30 men who will make up the 1965 Georgia People-to-People Business Professional Leaders Goodwill Delegation to visit Europe and the Soviet Union.

### Third District

ROBERT COLLINS of Americus spoke to the Cordele Rotary Club February 24, 1965, on the medicare bill now before Congress.

### Fourth District

ERNEST PROCTOR, Chief of Staff of Coweta General Hospital, Newnan, was guest speaker at the monthly meeting of the Conservatives March 22, 1965. Dr. Proctor, a member of MAG's sub-committee on national legislation, spoke on the medicare bill.

CHARLES B. THOMAS, Newnan physician and surgeon, announced in February that HENRY C. DRAKE will be associated with him in the operation of the Newnan Medical Clinic, which opened in late February at 139 Jackson Street. Dr. Drake will be engaged in the practice of obstetrics and gynecology.

J. LARRY ROSS, a graduate of the Medical College of Georgia, Augusta, has joined the medical staff of the Villa Rica Clinic.

### Fifth District

Efforts to improve relations between medical and legal professions were discussed at a joint meeting of the Medico-Legal Committee of the Fulton County Medical Society and the Atlanta Bar Association March 4, 1965.

The joint panel, composed of J. FRANK WALKER, WILLIAM E. MITCHELL, ROBERT E. WELLS, Mr. Edward E. Dorsey, Chairman of the Atlanta Bar Association, Mr. Robert B. Harris, Mr. Rex T. Reeves and Mr. Bengaman L. Weinberg, met at the Academy of Medicine and was sponsored by the Fulton County Medical Society.

TED F. LEIGH, and JOSEPH L. IZENSTARK, Atlanta, participated in a panel discussion of career specialties for radiologic technologists at the Second Radiologic Technologist Student Seminar February 7, 1965.

BRUCE LOGUE and ELBERT TUTTLE recently addressed the Central Florida Medical Meeting in Orlando. Dr. Logue spoke on "Cardioversion," and Dr. Tuttle spoke on "New Insights into Urinary Tract Infection."

ARTHUR P. RICHARDSON, Dean of the Emory University School of Medicine, spoke to the meeting of the Atlanta Association for Retarded Children March 18, 1965. The theme of the meeting, held at the Fairhaven School, was "Avenues of Research in the Field of Mental Retardation."

JUDSON L. HAWK, JR., Atlanta, spoke on "Mother, Come Quickly," a look at the causes of accidents in children, to the members of the Auxiliary to the Fulton County Medical Society March 5, 1965, at the Academy of Medicine.

**Seventh District**

A. McCOY ROSE, JR., MARIETTA, is serving as the Cobb County Unit Chairman of the Patient Services Committee of the American Cancer Society. HOWARD M. SIGAL, Smyrna, is active in the Educational Program of the Society and its 1965 crusade.

**Eighth District**

E. R. JENNINGS of Brunswick has been named President for 1965 of the Georgia Chapter, American College of Surgeons.

DUNCAN B. McRAE, Telfair County, McRae, has been appointed a member of the Georgia State Board of Health by Governor Earl E. Sanders to succeed ALEX G. LITTLE, Valdosta, who has resigned.

**Ninth District**

During the early part of March, H. H. McNEELY, Toccoa, attended a postgraduate seminar devoted to various surgical techniques and procedures. Headquarters for the meeting of Abdominal Surgeons was the Jung Hotel, New Orleans. Dr. McNeely is associated with the Medical Arts Clinic in Toccoa.

ROGER HEMPHILL of Gainesville will be associated with J. G. WOODWARD in Dahlonga on a part-time basis until July 1, 1965, after which Dr. Hemphill will be permanently located in Dahlonga.

JOSEPH D. LEE will serve as President of the Augusta Area Tuberculosis Association for 1965-66. PRESTON D. ELLINGTON and T. S. BOEHM are members of the Executive Committee. Guest speaker at the election meeting was FRANK P. ANDERSON, Director of Augusta's Respiratory and Rehabilitation Center.

# AMA NYC 1965

**Make your reservation now for NYC—  
avoid the rush—avoid the lines—register today!**

**June 20-24, 1965 — 114th Annual Convention**

Come to New York City June 20-24. Be part of tomorrow's medicine and participate in the year's most extensive scientific meeting.

The excitement of America's largest city is available to you at the best time of the year, as you relax and review—in air conditioned comfort—the most recent developments in general practice and all the specialties.

- Six general scientific meetings
- 23 medical specialty programs
- 700 scientific and industrial exhibits
- Lectures, panel discussions, motion pictures and color television

Plan to attend—continue your postgraduate education.

**American Medical Association • 535 North Dearborn Street, Chicago, Illinois 60610**



**JOURNAL**  
OF THE MEDICAL  
ASSOCIATION

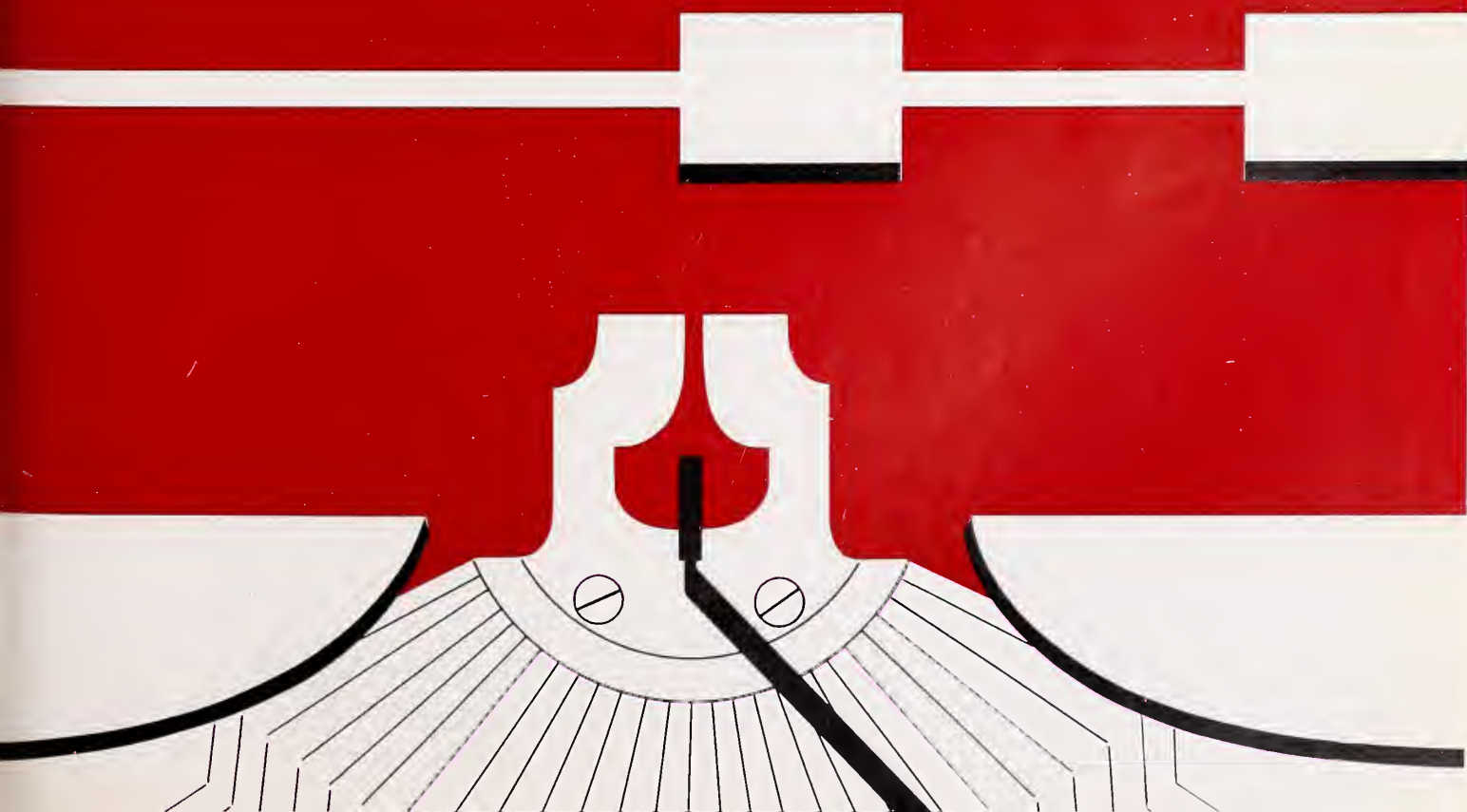
JUNE / 1965  
*Georgia*

U.C. MEDICAL CENTER LIBRARY

JUL 9 1965

San Francisco 22

# "Proceedings (issue) 111th Annual Session"





## Russian Thistle

(*Salsola pestifer*, A. Nelson)

### Distress for Allergic Patients

## Benadryl®

(diphenhydramine hydrochloride)

PARKE-DAVIS

### To Combat Symptoms of Weed-Pollen Allergy

This time-tested agent provides two actions that effectively combat symptoms of seasonal allergy: *Antihistaminic*—relieves sneezing, nasal congestion, itching, and lacrimation. *Antispasmodic*—relieves bronchial and gastrointestinal spasm. **Precautions:** Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers, if used with BENADRYL, should be prescribed with caution because of possible additive effect. Diphenhydramine

has an atropine-like action which should be considered when prescribing BENADRYL. **Side Effects:** Side reactions, commonly associated with antihistaminic therapy and generally mild, may affect the nervous, gastrointestinal, and cardiovascular systems. Most frequent reactions are drowsiness, dizziness, dryness of the mouth, nausea, and nervousness. BENADRYL is available in Kapseals® of 50 mg. and Capsules of 25 mg. diphenhydramine hydrochloride. The pink capsule with the white band is a trademark of Parke, Davis & Company.

**PARKE-DAVIS**

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232

72665





**JOURNAL**  
OF THE MEDICAL  
ASSOCIATION

Georgia

**Contents**

**EDITOR**

Edgar Woody, Jr., M.D.

**MANAGING EDITOR**

Merrillie M. Davis

**STAFF**

Thelma V. Franklin, *Business*

**CONTRIBUTING EDITORS**

Herbert S. Alden, M.D.; Preston D. Ellington, M.D.; Thomas Findley, M.D.; J. Willis Hurst, M.D.; Charles S. Jones, M.D.; Arthur M. Knight, Jr., M.D.; Arthur J. Merrill, M.D.; Lester Rumble, Jr., M.D.; Peter L. Scardino, M.D.; Patrick C. Shea, Jr., M.D.; Robert H. Vaughan, M.D.

**PUBLICATIONS COMMITTEE**

J. G. McDaniel, M.D.; George H. Alexander, M.D.; George R. Dillinger, M.D.; John Kirk Train, M.D.; A. W. Simpson, M.D.; John T. Mauldin, M.D.; John S. Atwater, M.D.; C. R. Andrews, M.D.

**THE ASSOCIATION**

George H. Alexander, M.D., *Pres.*; Walter E. Brown, M.D., *Pres.-Elect*; J. G. McDaniel, M.D., *Past Pres.*; Charles R. Andrews, Jr., M.D., *Chm. of Council*; John T. Mauldin, M.D., *Sec.*; John S. Atwater, M.D., *Treas.*; J. Frank Walker, M.D., *Speaker*; Mr. Milton D. Krueger, *Exec. Sec.*; Mr. James M. Moffett, *Asst. Exec. Sec.*; Mrs. Catherine Wooten, *Asst. Exec. Sec.*

THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and copyrighted, 1965, by the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309. Published monthly under the direction of the Council of the Association. Subscription rate: \$7 per year; \$1 per single copy. Second-class postage paid at Atlanta, Georgia.

**The Annual Session**

OFFICIAL PROCEEDINGS, 111TH ANNUAL SESSION  
OF THE MEDICAL ASSOCIATION OF GEORGIA,  
MAY 2-4, 1965, AUGUSTA, GEORGIA

1965 ANNUAL SESSION HIGHLIGHTS . . . . .	173
CANDID CAMERA . . . . .	228

**House of Delegates**

FIRST SESSION . . . . .	177
MONDAY, MAY 3, 1965	
SECOND SESSION . . . . .	179
TUESDAY, MAY 4, 1965	

**General Business Sessions**

FIRST . . . . .	222
SUNDAY, MAY 2, 1965	
SECOND . . . . .	224
MONDAY, MAY 3, 1965	
THIRD . . . . .	225
TUESDAY, MAY 4, 1965	

**Editorials**

SAVANNAHIAN, WALTER E. BROWN, CHOSEN NEW MAG PRESIDENT-ELECT . . . . .	230
MANNITOL AND ACUTE RENAL FAILURE . . . . .	231

**Features**

President's Letter . . . . .	232
Cancer Page . . . . .	233
Heart Page . . . . .	235
Mental Health Page . . . . .	236

**The Association**

Deaths . . . . .	237
Societies . . . . .	238
Personals . . . . .	238
Advertising Index . . . . .	36A
Calendar . . . . .	231

**Cover**

Design by Joe McKibben, Atlanta

Wherever you go in Georgia...



Total  
Resources  
over  
\$500  
Million

# **TRUST COMPANY OF GEORGIA**

*Where Banking is a Pleasure*

Atlanta, and affiliated banks

**THE FIRST NATIONAL BANK  
& TRUST COMPANY** of Augusta

**THE FOURTH NATIONAL BANK**  
of Columbus

**THE FIRST NATIONAL BANK  
& TRUST COMPANY** in Macon

**TRUST COMPANY OF GEORGIA  
BANK OF DeKALB**  
North Atlanta

**THE FIRST NATIONAL BANK**  
of Rome

**THE LIBERTY NATIONAL  
BANK & TRUST COMPANY**  
of Savannah

**MEMBERS:** Federal Deposit Insurance Corporation



# 1965 ANNUAL SESSION *Highlights*

## **Medical Men Act On Far Reaching Policies**

THE 111TH ANNUAL SESSION of the Medical Association of Georgia meeting in Augusta, May 2, 3 and 4 was well attended by the general membership and by the elected representatives to the MAG House of Delegates. The outstanding characteristic of the 1965 state meeting was the increased participation in and concern for the affairs and activities of the Association. The House of Delegates held its most active and enthusiastic session in many years and the politics of the profession drew considerable interest as new officers and an additional AMA Delegate were elected.

*Among the many reports and resolutions on a wide variety of subjects considered by the House were: relative value schedules; mental health; redistricting of Councilor districts; voluntary collection of GaMPAC dues; compulsory physical education in public schools; area wide planning; pre-marital examinations; increase in MAG presidential honorarium and others.*

### **Relative Value Schedule**

The report of the Reference Committee on the controversial question of MAG approval of a relative value schedule proposed that the matter be received for information and that final action be delayed until the Annual Session of 1966 with the intervening time to be used by all members of MAG to study the schedule recommended by the Relative Value Study Committee.

The House voted its approval instead of a floor substitute which created a negotiating committee composed of representatives of all specialty and subspecialty groups, and including the Academy of General Practice. The floor substitute further authorized said committee to negotiate a fee schedule for each of the specialties and passed on to the MAG Council authority for final ap-

proval. The floor substitute also provided for mandatory review of the full schedule every three years, or any part of the schedule relating to a particular specialty upon receipt of a petition signed by 50% of the members of that specialty.

The House further voted to assign this matter to a special reference committee (with no other business to deliberate) at the 1966 meeting of the House of Delegates.



Medical Association of Georgia Officers: From left—Walter E. Brown, Savannah, President-Elect; Lamar B. Peacock, Atlanta, First Vice President; George H. Alexander, Forsyth, President; J. G. McDaniel, Atlanta, Past President.

### **Mental Health**

The House approved an amended nine point statement of principles on the subject of mental health programming. The nine points involve: MAG cooperation, local financial responsibility, psychiatric indigency, patient pay and part-pay schedule, physician pay for services, local professional boards authorized to tailor programs as necessary, physician referral of patients to treatment centers, physician-directors for each of said clinics, and proper notification and consent of parents or guardians of all patients referred to such clinics.

The House also reaffirmed its previous recommendations regarding insurance coverage for mental illness and voted to appoint a committee who will direct its efforts toward this end in Georgia.

### **Redistricting**

The House approved a plan for the redistricting of Councilor districts following the presently drawn Congressional district lines. It further approved a recommendation from Reference Committee that the new lines of Councilor districts become effective January, 1966, *but that those Councilors in office on that date be permitted to serve until the 1966 Annual Session.*

### **GaMPAC**

The House voted its approval of a plan whereby the voluntary collection of dues for the Georgia Medical Political Action Committee could be accomplished through the mechanics of the regular billing procedure for the various echelons of medical organization.

This matter, recommended to the House in a supplemental report of the Council, was patterned in principle after a similar recommendation approved by the AMA House of Delegates at its 1964 meeting in Miami.

### **Compulsory Physical Education**

In approving the report of the Subcommittee on School Child Health the House put MAG on record in favor of compulsory physical education for all physically qualified students in Georgia's public schools. The House also gave its approval to an educational anti-smoking campaign which the School Child Health Subcommittee hopes to implement as soon as ways and means are developed.

### **Area Wide Planning**

A report issued by the Hospital Activities Board calling for greater physician participation on local area wide planning (of health facilities) committees evoked lively discussion and comment. Floor discussion of this matter brought out that area wide planning of health facilities is presently going on and that in many



instances the committees formulating these plans are doing so without the benefit of any medical direction. The House then voted to create a committee to investigate the feasibility of M.D. representation on all area wide planning committees and instructed the committee to make a report on this activity to the MAG Council in six months.

**Premarital Examinations**

*Two resolutions regarding premarital examinations were disapproved by the reference committee who in turn proposed its own resolution on this subject. Said resolution asked for legislation to establish a three-day waiting period prior to marriage for all people without regard to physical condition, including pregnancy.*

**Other Actions of the House**

The House also approved a resolution calling for the "fire-proofing of clothing materials; requested that greater emphasis be given to the subject of medical ethics; increased MAG presidential honorariums from \$1,000 and expense allowances to \$2,400 and certain expenses; amended Constitution and Bylaws to permit Past Presidents to serve as full members of Council for three years; adopted a resolution proposing that each hospital medical staff obtain its own distinctive and identifying letterheads; requested a resolution of commendation for the AMA to be introduced in the

AMA House of Delegates and, granted affiliate membership in MAG to Albert Tuck, D.D.S., Past President of the Georgia Dental Association.

**New Officers**

The following new officers were elected and/or installed for the coming year: *George Alexander, Forsyth, President; Walter Brown, Savannah, President-Elect; Charles Andrews, Canton, Chairman of Council; J. Frank Walker, Atlanta, Speaker, House of Delegates; Harrison Rogers, Atlanta, Vice Speaker. Preston B. Ellington, Augusta was elected new AMA Delegate.*

**OFFICIAL PROCEEDINGS**

**111th Annual Session—Medical Association of Georgia  
Augusta, Georgia, May 2-4, 1965**

- House of Delegates*
  - First Session*
  - Second Session*
- General Business Sessions*
  - First*
  - Second*
  - Third*

**PROCEEDINGS INDEX**

**(First Session)**

Attendance . . . . .	177
Reference Committees . . . . .	177
Credentials and Tellers Committees . . . . .	177
Approval of 1964 Minutes . . . . .	177
Annual Reports . . . . .	178
General Practitioner of the Year Award . . . . .	178
Late Reports . . . . .	178
Supplementary Reports . . . . .	179
Resolutions . . . . .	179

**(Second Session)**

Attendance . . . . .	179
Election of House Speaker and Vice Speaker . . . . .	180
Report of Reference Committee No. 1 . . . . .	180
Report of Reference Committee No. 2 . . . . .	191
Report of Reference Committee No. 3 . . . . .	202
Report of Reference Committee No. 4 . . . . .	208
Report of Reference Committee No. 5 . . . . .	214

Reports, Reference Committee Recommendations and Delegates Actions:

President . . . . .	180
President-Elect . . . . .	182
Immediate Past President . . . . .	184
First Vice President . . . . .	185
Second Vice President . . . . .	185



Secretary . . . . .	185
Treasurer . . . . .	186
Speaker, House of Delegates . . . . .	189
AMA Delegates . . . . .	202
AMA Alternate Delegate . . . . .	204
Council of MAG . . . . .	191
First District Councilor . . . . .	209
Third District Councilor . . . . .	204
Fourth District Councilor . . . . .	205
Fourth District Vice Councilor . . . . .	205
Fifth District Councilor . . . . .	206
Sixth District Councilor . . . . .	209
Seventh District Councilor . . . . .	210
Eighth District Councilor . . . . .	210
Ninth District Councilor . . . . .	211
Tenth District Councilor . . . . .	211
Tenth District Vice Councilor . . . . .	211
Fulton County Councilor . . . . .	206
Fulton County Vice Councilor . . . . .	207
Georgia Medical Society Councilor . . . . .	209
Muscogee County Councilor . . . . .	204
Richmond County Councilor . . . . .	212
Annual Session . . . . .	215
Constitution and Bylaws . . . . .	197
Finance . . . . .	194
Governmental Medical Services . . . . .	215
Disaster Medical Care Subcommittee . . . . .	216
Maternal and Infant Welfare Subcommittee . . . . .	216
Public Health Subcommittee . . . . .	214
Hospital Activities . . . . .	212
Blood Banks Subcommittee . . . . .	212
Hospital Relations Subcommittee . . . . .	213
Insurance and Economics . . . . .	
Medical Defense Subcommittee . . . . .	189
Relative Value Study Subcommittee . . . . .	197
Legislation . . . . .	217
Medical Education . . . . .	190
Occupational Health . . . . .	190
Professional Conduct Committee . . . . .	214
Public Service Board . . . . .	207
Medicine and Religion Subcommittee . . . . .	207
Weekly Health Column Subcommittee . . . . .	208
Special Activities . . . . .	218
Mental Health Subcommittee . . . . .	198
Woman's Auxiliary to the Medical Association of Georgia . . . . .	200
Woman's Auxiliary Advisory . . . . .	197
Allied Reports:	
Report of the <i>Journal of MAG</i> . . . . .	199

Late Reports, Reference Committee Recommendations and  
Delegates' Actions:

Late Report No. X-1 (Second District Vice Councilor) . . . .	219
Late Report No. X-2 (Board of Interprofessional Relations) . .	200
Late Report No. X-3 (Subcommittee on Cancer) . . . . .	219
Late Report No. X-4 (School Child Health Subcommittee) . . .	219

Resolutions, Reference Committee Recommendations and  
Delegates' Actions:

Resolution No. 1 (Premarital Examination) . . . . .	221
Resolution No. 2 (The Practice of Radiology in Hospitals) . .	213
Resolution No. 3 (Letterhead for Each "Medical Staff") . . .	213
Resolution No. 4 (Insurance Coverage for Mental Illness) . . .	201
Resolution No. 5 (Separation of Hospital Charges and Professional Fee in Radiologic Services Performed in Hospitals) . . . .	213
Resolution No. 6 (Fireproofing for Clothing) . . . . .	191
Resolution No. 7 (Compulsory State Medicine) . . . . .	221
Resolution No. 8 (Premarital Examination) . . . . .	222

Supplementary Reports, Reference Committee  
Recommendations, and Delegates' Actions:

Supplemental Report of Council No. A (Voluntary Collection of GaMPAC Dues) . . . . .	201
Supplemental Report of Legislative Board No. B (Status Report of "Medicare" Legislation) . . . . .	220
Supplemental Report of Council No. C (AMA Commendation) .	201
Supplemental Report of Council No. D (Amendment to Constitution and Bylaws to Permit Intermediate Past President to Serve on Council for Three Years) . . . . .	197
Supplemental Report of Council No. E (Informational Report of Ad Hoc Committee on Cardiovascular Disease) . .	202

**MAG GENERAL BUSINESS SESSIONS**

**(First Session)**

Nominations . . . . .	223
GP of the Year Award . . . . .	224

**(Second Session)**

MAG Memorial Service . . . . .	225
--------------------------------	-----

**(Third Session)**

Fifty-Year Certificates . . . . .	225
Scientific Exhibits Awards . . . . .	225
GP of the Year Award . . . . .	226
Certificates of Appreciation . . . . .	226
Hardman Award . . . . .	226
Distinguished Service Award . . . . .	226
Special Presentation . . . . .	226
Site of 1967 Annual Session . . . . .	226
Election Results . . . . .	226
Official Attendance Records . . . . .	226
Installation of Officers . . . . .	226



# FIRST SESSION, HOUSE OF DELEGATES

MONDAY, MAY 3, 1965

THE FIRST SESSION of the House of Delegates of the Medical Association of Georgia was called to order by Speaker J. Frank Walker, Atlanta, at 9:35 a.m., in the Embassy Room, Augusta Town House Motor Hotel, Augusta, Georgia, in conjunction with the 111th Annual Session of the Medical Association of Georgia.

Speaker Walker announced that he had received the preliminary report of the delegates' attendance from T. A. Sappington, Thomaston, Chairman of the House of Delegates Credentials Committee, and that there was a quorum of over 40 members present and accounted for. A complete report, made by the Credentials Committee on the attendance at the First Session of the House of Delegates follows:

## Attendance

In a compilation of attendance taken from the official roll, 48 county medical societies were represented by their duly elected delegates or alternates. Twenty-six medical societies were not represented at this First Session. Of a total of 156 authorized delegates from their respective medical societies, the official roll showed 113 delegates present at this First Session.

ALTAMAHA: J. B. Brown; BALDWIN: E. Y. Walker; BIBB: Waddell Barnes, Jasper T. Hogan, Jr., Ferdinand V. Kay, M. C. Newton, Charles R. White; BULLOCH-CANDLER-EVANS: John D. Deal; CAMDEN-CHARLTON: Joseph M. Jackson; CARROLL-DOUGLAS-HARALSON: J. Harvey Beall; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CLAYTON-FAYETTE: Wells Riley; COBB: Remer Y. Clark, Robert P. Coggins, Luther G. Fortson, Jr., T. J. VanSant, Jr.; DECATUR-SEMINOLE: Henry S. Bridges; COOK-BERRIEN: James C. Dismuke, Jr.; DEKALB: Earnest C. Atkins, M. D. Lockhart, E. H. McDowell, Richard C. Parsons, M. F. Simmons, Luther M. Vinton, Jr.; EMANUEL: R. J. Moye; FLINT: J. T. Christmas; FLOYD: R. E. Andrews, Jr., Richard Gray, James H. Smith; FULTON: Sam Ambrose, Thomas J. Anderson, Jr., Linton H. Bishop, Jr., F. W. Dowda, Charles Eberhart, Edwin C. Evans, John T. Godwin, Irving L. Greenberg, L. Harvey Hamff, Frederick F. Hardin, J. Frank Harris, J. Harold Harris, Haywood N. Hill, Fleming Jolley, J. Watts Lipscomb, William D. Logan, Jr., John N. McClure, J. D. Martin, Jr., J. Lamar Mays, William W. Moore, Lamar B. Peacock, H. L. Rogers, John K. Shellack, Charles E. Todd, J. Frank Walker, Robert E. Wells, Frank L. Wilson, Joseph S. Wilson; GEORGIA MEDICAL SOCIETY: John L. Elliott, W. H. Fulmer, Lawrence Lee, Jr., F. T. Nichols, Jr., William W. Osborne, Jules Victor, Jr.; GLYNN: C. A. Wilson; GORDON: William R. Thompson; HABERSHAM: Jack B. Edwards; HALL: Billy S. Hardman, A. D. Wright; JACKSON-BARROW: Paul T. Scoggins; CRAWFORD W. LONG: F. M. McElhannon; McDUFFIE: Albert G. LeRoy; MUSCOGEE: Roy L. Gibson, Luther J. Roberts, Charles R. Smith, Luther J. Smith, II, Luther H. Wolff; NEWTON-ROCKDALE: J. R. Sams; OCMULGEE: C. M. Johnson; PEACH BELT: H. E. Weems; RABUN: C. P. Lampros; RICHMOND: Clyde A. Burgamy, Preston D. Ellington,

Alfred J. Green, Julius T. Johnson, R. C. McGahee, Henry D. Scoggins, Walter L. Sheppard, A. J. Waters, Cecil A. White, Jr.; SOUTH GEORGIA: S. H. Story; SOUTHEAST GEORGIA: Michael H. Whittle; SPALDING: Alex P. Jones, James M. Skinner; STEPHENS: Irving D. Hellenga; SUMTER: J. R. Robinson; TAYLOR: E. C. Whatley; TELFAIR: C. J. Maloy; THOMAS-BROOKS: Frank R. Miller, John B. Morton; TRI-COUNTY: Frank T. Robbins; TROUP: C. T. Cowart, R. D. Dean; UPSON: T. A. Sappington; WARE: Floyd Davis, L. C. Durrence; WALKER-CATOOSA-DADE: M. K. Cureton, John P. Hoover; WASHINGTON: M. W. Hurt; WAYNE: Ollie O. McGahee; WHITEFIELD: Royal S. Farrow; D. A. Wells; WILKES: John E. Pollock, Jr.

## Reference Committees

Speaker Walker appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE NO. 1: J. H. Beall, Carrollton, Chairman; Waddell Barnes, Macon, Vice Chairman; Alex Jones, Griffin, Secretary; J. B. Brown, Baxley; Charles Watkins, Ellijay; James E. Baugh, Milledgeville; J. D. Deal, Statesboro; John Godwin, Atlanta; Roy L. Gibson, Columbus.

REFERENCE COMMITTEE NO. 2: Harrison Rogers, Atlanta, Chairman; C. A. Wilson, Brunswick, Vice Chairman; A. G. LeRoy, Thomson, Secretary; C. J. Roper, Jasper; A. G. Funderburke, Moultrie; Robert P. Coggins, Marietta; R. D. Waller, Albany; Fenwick Nichols, Savannah; A. Jack Waters, Augusta.

REFERENCE COMMITTEE NO. 3: Cecil White, Augusta, Chairman; Wells Riley, Jonesboro, Vice Chairman; Charles Todd, Atlanta, Secretary; Henry Bridges, Bainbridge; Walter Voyles, Waynesboro; A. Richard Grey, Rome; Billy Hardman, Gainesville; F. M. McElhannon, Athens; Z. V. Morgan, Jr., Decatur.

REFERENCE COMMITTEE NO. 4: J. T. Christmas, Vienna, Chairman; Lamar Peacock, Atlanta, Vice Chairman; Charles R. Smith, Columbus, Secretary; James Dismuke, Adel; S. H. Story, Valdosta; F. M. Lindsey, Warner Robins; F. Richard Miller, Thomasville; J. Frank Harris, Atlanta; Clyde Burgamy, Augusta.

REFERENCE COMMITTEE NO. 5: W. W. Osborne, Savannah, Chairman; C. Peter Lampros, Clayton, Vice Chairman; M. Freeman Simmons, Decatur, Secretary; Ollie McGahee, Jesup; M. H. Whittle, Lyons; L. C. Durrence, Waycross; M. K. Cureton, LaFayette; Albert Rayle, Atlanta; Charles R. White, Macon.

## Credentials and Tellers Committees

Speaker Walker announced the prior appointments of the House of Delegates Credentials Committee and Tellers Committee as follows:

CREDENTIALS COMMITTEE: T. A. Sappington, Thomaston, Chairman; Irving Greenberg, Atlanta; and Milledge C. Newton, Macon.

TELLERS COMMITTEE: Robert McGahee, Augusta, Chairman; T. J. VanSant, Jr., Marietta; and James Skinner, Griffin.

## Approval of 1964 Minutes

To expedite the reading and adoption of the minutes of the 1964 Sessions of the House of Delegates held in conjunction with the 110th Annual



Session of the Medical Association of Georgia meeting May 3-6, 1964, at Macon, Georgia, the chair entertained a motion that the minutes as published in the June, 1964, issue of the *Journal of the Medical Association of Georgia* be approved. On motion duly made and seconded, it was noted that these minutes be so approved as published in their entirety in the June, 1964, issue of the *JMAG*.

### Annual Reports

Speaker Walker called for the Annual Reports of Officers, Council, Councilors, and Vice Councilors, Association Committees and Boards and Sub-Committees. The reports of Officers, Council, Councilors and Vice Councilors, Association Committees and Boards and Board Sub-Committees, and Allied reports as introduced at this Session are listed below with the Reference Committee to which they were referred. The full report, the action by the Reference Committee, and the House of Delegates action is listed under the proceedings of the Second Session of the House of Delegates. (See pages 179 to 222.)

#### OFFICERS

President—Reference Committee No. 1  
President-Elect—Reference Committee No. 1  
Immediate Past President—Reference Committee No. 1  
First Vice President—Reference Committee No. 1  
Second Vice President—Reference Committee No. 1  
Secretary—Reference Committee No. 1  
Treasurer—Reference Committee No. 1  
Speaker of the House—Reference Committee No. 1  
AMA Delegates—Reference Committee No. 3  
AMA Alternate Delegate—Reference Committee No. 3

#### COUNCIL

Council of MAG—Reference Committee No. 2

#### COUNCILORS AND VICE COUNCILORS

First District Councilor—Reference Committee No. 4  
Third District Councilor—Reference Committee No. 3  
Fourth District Councilor—Reference Committee No. 3  
Fourth District Vice Councilor—Reference Committee No. 3  
Fifth District Councilor—Reference Committee No. 3  
Sixth District Councilor—Reference Committee No. 4  
Seventh District Councilor—Reference Committee No. 4  
Eighth District Councilor—Reference Committee No. 4  
Ninth District Councilor—Reference Committee No. 4  
Tenth District Councilor—Reference Committee No. 4  
Tenth District Vice Councilor—Reference Committee No. 4  
Georgia Medical Society Councilor—Reference Committee No. 4  
Muscogee Medical Society Councilor—Reference Committee No. 3  
Fulton Medical Society Councilor—Reference Committee No. 3  
Fulton Medical Society Vice Councilor—Reference Committee No. 3  
Richmond Medical Society Councilor—Reference Committee No. 4

#### ASSOCIATION COMMITTEES

Finance—Reference Committee No. 2  
Professional Conduct—Reference Committee No. 5  
Woman's Auxiliary Advisory—Reference Committee No. 2

#### BOARDS AND SUBCOMMITTEES

Annual Session Board—Reference Committee No. 5  
Constitution and By-Laws Board—Reference Committee No. 2  
Governmental Medical Services Board—Reference Committee No. 5  
Disaster Medical Care Subcommittee—Reference Committee No. 5  
Maternal and Infant Welfare Subcommittee—Reference Committee No. 5  
Public Health Subcommittee—Reference Committee No. 5  
Hospital Activities Board—Reference Committee No. 4  
Blood Banks Subcommittee—Reference Committee No. 4  
Hospital Relations Subcommittee—Reference Committee No. 4  
Relative Value Study Subcommittee—Reference Committee No. 2  
Medical Defense Subcommittee—Reference Committee No. 1  
Legislation Board—Reference Committee No. 5  
Medical Education Board—Reference Committee No. 1  
Occupational Health Board—Reference Committee No. 1  
Public Service Board—Reference Committee No. 3  
Medicine and Religion Subcommittee—Reference Committee No. 3  
Weekly Health Column Subcommittee—Reference Committee No. 3  
Special Activities Board—Reference Committee No. 5  
Mental Health Subcommittee—Reference Committee No. 2

#### ALLIED REPORTS

Report of the *Journal*—Reference Committee No. 2  
Report of the Woman's Auxiliary to the MAG—Reference Committee No. 2

### General Practitioner of the Year Award

Speaker Walker presented the two nominations for the 1965 Georgia General Practitioner of the Year Award as received from the Association's First General Business Session. The two nominees presented were: Charles H. Dickens of Madison, Georgia, and Robert G. Stephens of Washington, Georgia. Dr. Walker then asked the delegates to mark their "GP of the Year" Ballot with the name of the candidate of their choice for this high honor. Tellers Committee Chairman Robert McGahee, of Augusta, then reported that Dr. Robert G. Stephens of Washington, Georgia, had been elected the 1965 General Practitioner of the Year, and Speaker Walker announced that this award would be presented at the final MAG General Business Session, May 4.

### Late Reports

Speaker Walker then announced as the first order of new business, he wished to present and refer Late Reports received after the deadline for the printing of the Delegates Handbook. These late reports as received, and referred to reference committee, are as follows:

Late Report X-1: Second District Vice Councilor—Reference Committee No. 5  
Late Report X-2: Interprofessional Relations Board—Reference Committee No. 2  
Late Report X-3: Subcommittee on Cancer—Reference Committee No. 5  
Late Report X-4: School Child Health Subcommittee—Reference Committee No. 5



## Supplementary Reports

Speaker Walker announced that as the second order of new business, he wished to present Supplementary Reports for referral to a House Reference Committee. Dr. Walker stated that as a supplementary report adds something new to an existing report previously submitted, he therefore would refer these supplementary reports to the same reference committee that received the original report. The following supplementary reports were then referred as follows:

Supplementary Report A: MAG Council—Voluntary Collection of GaMPAC Dues—Reference Committee No. 2

Supplementary Report B: Legislative Board—Status Report on “Medicare” Legislation—Reference Committee No. 5

Supplementary Report C: Council—AMA Commendation—Reference Committee No. 2

Supplementary Report D: Council—Amendment to Constitution and By-Laws to Permit Immediate Past President To Serve On Council For Three Years—Reference Committee No. 2

Supplementary Report E: Council—Informational Report of Ad Hoc Committee on Cardiovascular Disease—Reference Committee No. 2

Supplementary Report F: Council—Resolution of Sympathy, In Memoriam

At this time, Speaker Walker requested the author of Supplementary Report of Council No. F, Dr. Addison W. Simpson, Jr., Chairman of Council, to read this supplementary report as follows:

“WHEREAS, Almighty God, in His Infinite Wisdom, has seen fit to take suddenly from our midst, Mister Carl Thomas Sanders, father of The Honorable Carl E. Sanders, Jr., Governor of the State of Georgia, and

“WHEREAS, the members of the Medical Association of Georgia wish to express their deep sympathy, and

“BE IT RESOLVED: that the House of Delegates of the Medical Association of Georgia in executive session adopts this minute acknowledging this loss and,

“BE IT FURTHER RESOLVED: that a copy of this resolution of sympathy be permanently placed in the minutes of this meeting, and that a copy be sent to Governor Carl E. Sanders with our condolence.”

On motion duly made and seconded, it was moved that the House as a reference committee of the whole adopt Supplementary Report of Council No. F: Resolution of Sympathy, In Memoriam. This resolution was then adopted unanimously by the House.

## Resolutions

Speaker Walker then called for the introduction of Resolutions as the next item of new business. The following Resolutions were presented:

Resolution No. 1: Premarital Examination—Reference Committee No. 5

Resolution No. 2: The Practice of Radiology in Hospitals—Reference Committee No. 4

Resolution No. 3: Letterhead for each “Medical Staff”—Reference Committee No. 4

Resolution No. 4: Insurance Coverage of Mental Illness—Reference Committee No. 2

Resolution No. 5: Separation of Hospital Charges and Professional Fee In Radiologic Services Performed in Hospital—Reference Committee No. 4

Resolution No. 6: Fireproofing for Clothing—Reference Committee No. 1

Resolution No. 7: Compulsory State Medicine—Reference Committee No. 5

Resolution No. 8: Premarital Examination—Reference Committee No. 5

Speaker Walker called for other Resolutions and there being none, he then explained that the *Incoming President's Address* as given earlier at the Second General Business Session would now be received by the House and referred to Reference Committee No. 1.

There being no further business, Speaker Walker recessed the First Session of the MAG House of Delegates at 10:30 a.m. on motion duly made and seconded.

# SECOND SESSION, HOUSE OF DELEGATES

(RECESSED)

**TUESDAY, MAY 4, 1965**

THE SECOND SESSION (Recessed) of the House of Delegates of the Medical Association of Georgia held in conjunction with the 111th Annual Session of the Association was called to order by Speaker J. Frank Walker at 2:35 p.m., in the Embassy Room, Augusta Town House Motor Hotel, Augusta, Georgia, on May 4, 1965.

Speaker Walker announced that the Credentials Committee Chairman reported an attendance in excess of 40 members registered and accounted for, therefore, Dr. Walker declared a quorum present

and the House of Delegates in session. The Credentials Committee made the following complete report on attendance at the close of the meeting.

## Attendance

In a compilation of attendance taken from the official roll, 45 county medical societies were represented by their duly elected delegates or alternates. Twenty-nine county medical societies had no representatives at the Second Session. Of a total of 156 authorized delegates from their respective medical



societies, the official roll showed 105 delegates present at this Second Session.

BIBB: Waddell Barnes, Ferdinand V. Kay, Charles R. White; BULLOCH-CANDLER-EVANS: John D. Deal; BURKE: B. Lamar Murray; CAMDEN-CHARLTON: Joseph M. Jackson; CARROLL-DOUGLAS-HARALSON: J. Harvey Beall, J. F. Green; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CLAYTON-FAYETTE: Wells Riley; COBB: Robert P. Coggins, Luther G. Fortson, Jr., T. J. VanSant, Jr.; COWETA: Robert M. Webster; DECATUR-SEMINOLE: Henry A. Bridges; COOK-BERRIEN: James C. Dismuke, Jr.; DEKALB: E. C. Atkins, M. D. Lockhart, E. H. McDowell, M. F. Simmons, Luther M. Vinton, Jr.; DOUGHERTY: Robert D. Waller; EMANUEL: R. J. Moye, FLINT: J. T. Christmas; FLOYD: Russell E. Andrews, Richard Gray, James H. Smith; FULTON: Sam Ambrose, Thomas J. Anderson, Jr., LeRoy C. Antrobus, Linton H. Bishop, Jr., Robert Carter Davis, F. W. Dowda, Charles E. Dowman, Charles Eberhart, Edwin C. Evans, Irving L. Greenberg, E. L. Griffin, L. Harvey Hamff, Fred Hardin, J. Harold Harrison, Fleming Jolley, J. W. Lipscomb, William D. Logan, John McClure, J. Lamar Mays, Thomas R. Nolan, Lamar B. Peacock, William Pendergrast, A. A. Rayle, Jr., H. R. Rogers, Jr., John K. Schellack, Charles E. Todd, Robert E. Wells, Frank L. Wilson, Jr., Joseph S. Wilson; GEORGIA MEDICAL SOCIETY: John L. Elliott, W. H. Fulmer, Fenwick Nichols, Jr., W. W. Osborne; GLYNN: Clyde A. Wilson, Jr.; HALL: B. S. Hardman, A. D. Wright; JACKSON-BARROW: E. W. Holloway, Jr.; McDUFFIE: Albert G. LeRoy; MUSCOGEE: Roy Gibson, Charles R. Smith, Luther J. Smith, II, Luther H. Wolff; OCONEE VALLEY: George F. Green; PEACH BELT: F. M. Lindsey, H. E. Weems; RABUN: C. Peter Lampros; RICHMOND: Preston D. Ellington, William C. Fuller, A. J. Green, Julius T. Johnson, R. C. McGahee, Henry D. Scoggins, Walter L. Sheppard, C. A. White; SCREVEN: W. R. Kent; SOUTH GEORGIA: S. H. Story; SOUTHEAST GEORGIA: Michael H. Whittle; SPALDING: Alex P. Jones, James M. Skinner; STEPHENS: Irving D. Hellenga; SUMTER: J. R. Robinson; TAYLOR: E. C. Whatley; TELFAIR: C. J. Maloy; THOMAS-BROOKS: Frank R. Miller, John B. Morton; TROUP: C. T. Cowart, R. D. Dean; UPSON: T. A. Sappington; WARE: Floyd Davis, L. C. Durrence; WALKER-CATOOSA-DADE: M. K. Cureton, J. P. Hoover; WASHINGTON: Joseph E. Lever; WAYNE: Ollie O. McGahee; WHITFIELD: Royal S. Farrow, D. A. Wells; WILKES: John E. Pollock, Jr.

### Election of House Speaker and Vice Speaker

Speaker Walker announced that every third year, according to the MAG Constitution and By-Laws, there is provision at the Second Session of the House of Delegates for the election of Speaker and Vice Speaker as specified in Chapter III, Section 6 of the By-Laws as follows: "Election of Speaker and Vice Speaker (every third year at the Second Session of the House of Delegates during the Annual Session); their terms of office to begin with the adjournment of the House of Delegates . . ."

Speaker Walker stated that the Chair was open for nominations for the office of Speaker for the MAG House of Delegates and the following nominations were made:

*Speaker* — J. Frank Walker, Atlanta; nominated by Luther Wolff, Columbus; seconded by Irving Greenberg, Atlanta, and W. W. Osborne, Savannah.

There being no other nominations for the office of Speaker of the MAG House of Delegates, it was duly moved and seconded that the nominations be

closed, and the Secretary was instructed to cast the unanimous ballot for J. Frank Walker as Speaker of the House of Delegates of the Medical Association of Georgia.

*Vice Speaker* — Harrison Rogers, Atlanta; nominated by Peter Story, Atlanta; seconded by John McClure, Atlanta.

There being no other nominations for the office of Vice Speaker, it was duly moved and seconded that the nominations be closed, and the Secretary was instructed to cast the unanimous ballot for Harrison Rogers as Vice Speaker of the MAG House of Delegates.

### Reference Committee Reports

Speaker J. Frank Walker stated that the next order of business would be the Reference Committee Reports as follows:

#### Report of Reference Committee No. 1

J. H. Beall, Carrollton, Chairman

*(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)*

Reference Committee No. 1 met in the Embassy Room of the Augusta Town House Motor Inn, Augusta, Georgia, at 2:30 p.m., on May 3, 1965. Members present were J. H. Beall, Carrollton, Chairman; Waddell Barnes, Macon, Vice Chairman; Alex Jones, Griffin, Secretary; J. B. Brown, Baxley; J. D. Deal, Statesboro; John T. Godwin, Atlanta; and Roy L. Gibson, Columbus.

#### President

J. G. McDANIEL, M.D., Atlanta

This has been a happy year for me and by and large a very pleasing year — frustrations sure — several of the things that I had hoped to accomplish I didn't. Problems were presented that would tax the wisdom of Solomon — and the more I think about that wise man, the more I believe that only his eminently wise decisions were recorded. He must have fouled up a time or two.

Anyway, I set out this year to accomplish as major projects two things — (1) to do something about the fatal auto accidents in our state, and (2) to discuss medical education in Georgia as it relates to pre and postgraduate education and the over-specialization of medicine.

In the first project there were two parts: (a) to increase the highway patrol in numbers; (b) to require citizens in the older age group to have a driver's license test every five years. This test would be a simple one as follows: Put a person in his own automobile with a designated patrolman and determine whether or not he or she could drive the car over a prescribed course. This would take care of vision and ability to handle the car.

We heartily endorsed the auto inspection law and I



spoke before the Georgia General Assembly legislative committee in favor of this. We, among others, were successful in increasing the number of highway patrolmen, but unfortunately, the bill providing for examination of older drivers was deferred until next year. The legislative committee had run into so much trouble with the auto inspection law that they were not enthusiastic about new legislation of any kind pertaining to traffic safety. They wanted all such tests spelled out which we could not do in the few days allotted us. I must say, however, that the Governor's Committee on Traffic Safety went along with the idea 100 per cent and one of their members introduced the bill.

I believe that it will pass next year, especially if we keep hammering at it—and this I recommend. We all know that as our citizens are living longer, we have more and more who can't see well; whose coordination is not good and who are handicapped with various diseases. As I explained to the legislative committee — if a man or woman is 100 years old and can drive a car well, then that's fine. We're not trying to remove his or her license, but if they can't see fifty feet or can't apply the breaks quickly, then they have no right to drive on our modern expressways or highways. The driver who comes into the highway in the path of an oncoming car running at 60 miles an hour because he couldn't see it, kills people, and the driver that pokes along at 20 to 30 miles per hour on the expressway or highway, because of some handicap, either physical or mental, kills people also. These things we can correct up to a certain point. The increased number of patrolmen should help control our speeders and drunken drivers. There again — up to a certain point — but they will positively reduce accidents.

The meeting on medical education headed by Dr. Tom Goodwin was a great success. I only wish that we could have had all the faculty of each medical school and all the physicians in the state there. As it was, we invited only 15 of the faculty from each school and 30 practicing physicians. A meeting of this sort just can't be too large or nothing can be accomplished. The meeting was attended well. We discussed the problems that confronted the medical schools in their education of young doctors and the problems that confront the practicing physicians over the state. It was tremendously worthwhile. I am sure Dr. Goodwin will give a report of this meeting.

And while I'm on the subject, we had a follow-up meeting in Macon to discuss the residencies of general or family practice offered by the non-university hospitals over the state. Something good should come from this.

The above were the two major things that I was shooting at, but in addition, there were many other things to be done. For example, we approved and I attended several meetings on the State marriage laws (3 day waiting period, etc.). We approved the voluntary sterilization bill, the oral cytology program, the anti-child abuse law. I met with a committee several times to see Governor Sanders on implementing the second phase of the Kerr-Mills program, which will become effective in 1966.

The MAG Executive Committee has had one meeting with the State Board of Health. They impressed us as a hard working Board. They are taking their work seriously and we have had excellent liaison throughout the year.

I have been in Chicago four or five times (at AMA expense) for various meetings on public relations, Kerr-Mills, etc. The Executive Committee appointed me as temporary delegate to the AMA to attend a called meeting of the House of Delegates in February of this year. This appointment was for this called meeting only, until a fourth delegate could be elected in May at this Annual Session.

I went to the AMA conventions in San Francisco and Miami. At each of these sessions, I attended the Conference of Presidents of State Medical Societies. It was learned that their problems are about the same as ours — and while I'm on the subject, the main thing that troubled us all was, the amount of time required to intelligently, or half-way intelligently be a president. Just about every day, some kind of crisis arises from either doctors, nurses, hospitals, paramedical groups, civic groups, or the AMA, to say nothing of politics. For example, several months ago a Veterans Administration official called me and said that fees for physicians treating veterans had not been raised in several years; that he was making out a report on the schedule of fees for Georgia — and did we want to help adjust them? I think we had some 7 to 10 days. There was, of course, no time to call the MAG Insurance Committee together to study the matter. So I discussed this with representatives of the various medical groups and came up with an increase of about 10 per cent above the fees set some five years ago. This was then approved by the Insurance Committee and Council. Next year we have a promise to have ample time for the Insurance Committee to work on this schedule of fees — but that's the way it is. There are just too many things happening and at the last minute somebody has the bright, and many times correct idea that "this should be cleared through MAG."

The meetings of MAG Council and the Executive Committee have been well attended. We have not always agreed on everything, but that is as it should be, else there would be no reason for a Council. On major things we have agreed, however, and we've accomplished a great deal. The hospitality and kindness shown us in the various cities where we met over the year has been a great joy to us all, especially the wives.

Many of the committees have worked hard and have done magnificent work. This I know, because I have attended some of their meetings.

The Woman's Auxiliary has been a source of great happiness. They are quite inspirational — not in the sense that a great preacher or orator inspires people — but if you'll just sit in a meeting and listen to the things they have accomplished and the things they plan to do — it will inspire you. Their deeds speak for themselves. They do not need oratory.

But this is enough; your President has had a busy year. I'm not complaining; I knew it was going to be that way when I agreed to take the job. It has been a comforting year too.

The staff of MAG has cooperated 100 per cent. Without them I don't know what any President would do, or as a matter of fact what the committees or the entire membership would do. I always had John Mauldin, our Secretary, Kirk Train, our Vice President, and Addison Simpson, our Chairman of Council, to lean against when the going was tough.

At the present time it's downright sinful the pleasure I get in deferring things for the next President to de-



cide — power to you, Dr. George Alexander of Forsyth, Georgia.

**REFERENCE COMMITTEE RECOMMENDATION**—This committee reviewed the President's report and recommended approval with commendation. This committee would like to emphasize the recommendation given regarding the medical concern of traffic safety, periodic examination of aged drivers and the continued medical education work.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the President as recommended by the Reference Committee on motion duly made and seconded.

### President-Elect

GEORGE H. ALEXANDER, M.D., *Forsyth*

With each passing year in working in the Medical Association of Georgia, I am learning that there is no such thing as a quiet, inactive year. The year 1964-65 certainly bears out the above.

As your President-Elect, it has been my pleasure and privilege to attend all of the Council meetings and all of the Executive Committee meetings with one exception when I was unable to be present.

During the past year, there have been other meaningful meetings which I have attended.

The last two days of November and the first two days of December, I attended the AMA Clinical Session in Miami. While there I was privileged, along with Dr. McDaniel, to attend the Conference of State Medical Society Presidents (also Presidents-Elect and Immediate Past Presidents). This Conference was very helpful in the exchange of ideas and problems at the State level and future conferences are planned at or following the AMA Annual and Clinical Sessions.

Also in Miami, we were invited to attend a meeting of the Council on Medical Education, to which representatives of all states touching the State of meeting were invited. This meeting was interesting and informative and provided an excellent prelude to the MAG Medical School Conference on Education held at Callaway Gardens January 29, 30 and 31. The Callaway Gardens' meeting was most interesting and I think laid the ground work for future meetings which can be of great value. A detailed report, I am sure, will be given by the Board of Medical Education.

Earlier in January, I attended — along with Dr. Mauldin and Mr. Krueger, a Conference in Chicago called by the AMA on Kerr-Mills. This was an informative and helpful conference preceding by a week the MAG Conference of State and County Medical Society leaders, at which we were honored by having Dr. Donovan Ward as our guest.

There have been many other activities during the year, the details of which I will not go into in this report. The highlights only are represented in the foregoing.

It has been a pleasure to serve during the year with the MAG President, the other MAG officers and the Council. I hope and believe that it has been a year during which I have learned many things, which I hope will better equip me to serve as President during the coming year. I will rely upon your help to make it a good year.

**REFERENCE COMMITTEE RECOMMENDATION**—This committee recommended approval with commendation.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the President-Elect as recommended by the Reference Committee on motion duly made and seconded.

## Lord, Make Us Rich and Honest

WHEN MY MOTHER was a young girl, she went to Albany, Georgia, to live with her aunt who had no children. The husband of her aunt was a former Confederate General and he became Mayor of his City and a Superior Court Judge.

This "Uncle Gib" was quite a character in many ways—one of his delights being derived by teasing "Auntie." Quite often when they would sit down for a meal he would ask the blessing by simply saying: "Lord, make us rich and honest." "Auntie" would remonstrate with him about this, but to no avail.

### In Grace and Religion

There came the occasion when some very proper and dignified guests came for dinner. When they were all seated at the table with their heads bowed, "Uncle Gib" said, "Lord, make us rich and honest"—and then after a pause he added—"rich in Thy Grace and honest in our religion"—much to the relief of "Auntie" and to the delight of the guests.

For the purpose of this talk, I think we might paraphrase a bit and say: "Lord, make us rich in Thy Grace and in our Heritage and Traditions. Also, we ask Thy help in keeping us honest in our convictions."

Using the foregoing story as a point of departure, there are some things which I would like to discuss with you briefly.

### Inherited Tradition

We physicians in Georgia and in our great country are certainly rich in His Grace and we have inherited a background rich in tradition. This background is well exemplified in our Hippocratic Oath and in the Code of Ethics of the American Medical Association to which we all subscribe.

Further exemplification may be found in a review of some of the more recent activities of our Association for the well-being of our State and its citizens.

The Milledgeville Hospital Study Committee is an outstanding example. We are all familiar with the "Schaefer Report" which served as the "launching pad" for improving the plight of the Milledgeville State Hospital and of our state's mentally ill people.

The Act to implement the Kerr-Mills program in Georgia was passed in 1961 with the support and endorsement of MAG, and we have continued to work for its full implementation.

The Georgia Hospital-Medical Council was organized under the sponsorship of the MAG Hospital



Relations Committee. This Council has done a tremendous job in setting standards for and inspecting and accrediting small hospitals. More recently a similar program has been started for the nursing homes in Georgia.

The Council has also served as a mediation board in problems involving relationships between hospital medical staffs, governing boards and administrators.

A more recent, excellent example of the convictions held by our profession can be found in the "Eldercare" proposal of our American Medical Association. You are well familiar with the details of this proposed program and they will not be discussed at this time. This plan was honest in its inception and in its proposals. Why not the AMERICAN WAY, allowing and expecting those able to pay all their health care costs to do so, while allowing those able to pay part to do so and, at the same time, providing at government expense for those unable to provide for themselves? There should be no "handout" for those who do not need it.

Unfortunately, when the House of Representatives passed the administration's Health Care Bill, it made the passage of "Eldercare" most unlikely. However, we must continue to work to salvage as much as possible of the principles in which we believe.

I must also remind you that our AMA House of Delegates has authorized a study to determine the feasibility of a program of care based upon need for those *below* the age of 65.

Lord, help us to be honest in our convictions and have the courage to stand by them.

### **Preservation of Tradition**

The foregoing, I feel, and I believe you will agree with me, involves the preservation of the traditional way of American life. Some comment is in order concerning those traditions pertaining to our profession and our relationship to our patients, our communities and our governments.

It shouldn't be necessary, but I will say that we should continue our efforts to preserve inviolate the physician-patient relationship. All of us are aware of the need for more doctors who are willing to train for and do "family practice" not only in the less populous areas of our state, but also in the heavily populated areas. The decreasing number of physicians entering this type of practice is leaving a great gap and is largely responsible for our deteriorated "public image."

This problem was graphically brought out by an article in *Medical Economics* under date of October 19, 1964. According to this article, the number of M.D.'s in private practice increased in 1964 over the number in 1960, whereas, in the same period

there was a decrease in the number of Generalists as well as the number of Internists and Pediatricians.

### **A Responsibility**

We have a responsibility to our communities to do all we can to reverse this trend. I realize that we certainly need highly trained and skilled men in all of the specialties and sub-specialties in which they are being trained but, in my opinion, and in the opinion of many others, too many men are entering those fields of practice and too small a portion of the total product of our medical schools is finding its way into family practice where the whole patient may be treated.

A step in the right direction was made this past January. Under the leadership of our President, Dr. J. G. McDaniel and Dr. Tom Goodwin, Chairman of our Board of Medical Education, the Georgia Conference on Medical Education was held. This Conference took place at Callaway Gardens and included 30 practicing physicians and 15 faculty representatives from each of our Medical Schools.

I feel that the liaison produced was excellent and resulted in a better insight on the part of both groups into the problems of the other. It is my hope that another Conference can be held during the coming year, and as often thereafter as practical and necessary—perhaps on an annual basis.

### **Para-Medical Personnel**

In connection with these Conferences, I would like to comment on the problem of para-medical personnel. Recently, I have been privileged to serve on the newly created Dean's Medical Alumni Advisory Council for the Emory School of Medicine. There has been a great deal of discussion by this Council concerning the para-medical personnel problem and the need for more trained people in these fields. It is felt that while there is such a great need for more doctors and that such need will increase in the future, it will continue to be a tremendous problem for our medical schools to train them in sufficient numbers. For this reason, it has been recommended by this Emory Council that the Medical School undertake a program of training for these para-medical people. To do so, it will be necessary that the medical schools abandon the concept that such training puts them in the position of operating a "trade school."

### **A Broadened Program**

These para-medical people should remain under the direction and supervision of Doctors of Medicine. Therefore, it would be unwise for a separate examining and licensing program to be set up for them as it might well result in efforts to set up laboratories



and services without proper medical supervision. For the foregoing reason, it is felt that certification would be preferable to licensure. Our larger hospitals are also in a position to operate these schools as are many of the larger clinical laboratories—and many do—but perhaps the program needs to be broadened.

Looking to the future—the physician will have to learn to be “Captain of a larger Team.”

It is recommended that the MAG Board of Medical Education and the Board of Legislation work with representatives of our medical schools and hospitals in planning such a training program. This could well be an important facet of the next MAG Medical School Conference on Medical Education when more detailed planning may be discussed.

You will recall that earlier our Code of Ethics was mentioned. Most of our profession have an inherent sense of right and wrong and try to live by it. Our Code of Ethics puts down in “black and white” the principles which should guide us in our conduct in relation to our patients, our community and our fellow physicians.

I wonder how many of us occasionally take the time to refresh ourselves as to what is contained in this Code. We should all take the time to do this as often as necessary to keep these principles fresh in our minds. While the vast majority of physicians abide by our Code, unfortunately we have an occasional maverick who will give the profession a black eye. We should always have the courage to stand by the principles enunciated in the Code and to stand behind our Professional Conduct Committees whenever it is necessary for them to act.

I urge that the MAG Professional Conduct Committee work with the constituent society committees, and where indicated to cooperate with our State Board of Medical Examiners in seeing that justice is obtained. This should be done whether the problem involves physician with physician relationship or physician-patient relationship or a breach by a physician of the Medical Practice Act. In the foregoing way, we can go far in upholding the honor and dignity of our profession. I would like to further recommend that during the coming year that all of our constituent societies devote one meeting to a program on medical ethics.

### Aid and Counsel

Among the responsibilities of medicine, I feel that we should, in the coming year, give our aid and counsel to those working on such problems as juvenile delinquency, our climbing crime rate, marriage mills and high divorce rate. Many problems remain which are more closely related to medicine

—such as, cancer, arthritis, cardiovascular disease and the increase in VD and mental illness. I want to urge the proper Boards or Committees of MAG to cooperate and work with and support the various organizations addressing themselves to the alleviation of these problems.

There is a responsibility at the community level which needs to be filled more adequately. When I was serving on the Georgia Hospital-Medical Council, some inspection reports brought out the fact that inadequate provision had been made for any emergency service at a few hospitals. The medical staff of any community hospital has a responsibility to see that such coverage is available at all times, and I urge all local medical societies and/or medical staffs to take necessary steps to see that emergency coverage is adequate.

### To Live With It

Finally, I would like to emphasize that whatever system of health care is evolved, we have a responsibility and obligation to live with it. At the same time, we must do our utmost to preserve high standards of patient care and the traditional physician-patient relationship. Also we must, by all means, continue our fight for the modification of the program in such a way as to bring it into line with the principles in which we believe, and also with the possible inclusion of those *in need* below the age of 65.

Right here, I would like to quote our AMA President, Dr. Donovan Ward, when in February of this year he said to the special meeting of the AMA House of Delegates: “It is never too late to pass good legislation and to defeat bad legislation. The only one thing in this historic decision . . . *the only thing* . . . that may truly come too late, is regret.”

In concluding, let me say that in our efforts to do some of the things discussed, it will be necessary to stand by our convictions and to have the courage to honestly work and fight for them. If we will but do this, then we may continue to be—“Rich in His Grace,” and rich as well as honest in our heritage and traditions.

**REFERENCE COMMITTEE RECOMMENDATION**—This committee received and reviewed the report of the Incoming President and recommended approval with commendation. This committee would recommend the continuance and augmentation of the recently appointed Committee on Paramedical Personnel to study certification and training programs for paramedical personnel. This topic caused considerable discussion and interest.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Incoming President as recommended by the Reference Committee with the additional recommendation made by the Reference Committee on motion duly made and seconded.

### Immediate Past President

GEORGE R. DILLINGER, M.D., *Thomasville*

You, the Medical Association of Georgia, honored



me by allowing me to serve as your President for 1963-64. I am grateful for having had that privilege, and thank each and everyone of you.

More than half a century ago, the Association determined that the president should be paid \$1,000.00 for his year in office. At that time the office of the presidency was an honor, requiring appearance at meetings and a few speeches. Today being President of MAG, requires many hours of work each week with a multiplicity of duties requiring extensive travel and expense.

I would like to recommend to the House of Delegates and Council, that the office of President of MAG be remunerated by an honorarium of \$5,000.00 a year, and necessary travel expenses.

In January 1965 a most significant meeting was held at Callaway Gardens. Thirty members of the faculty of our two medical schools, with thirty members of the leadership of MAG discussed medical education. So far as I am informed, no similar meeting has ever been held in this country. Such meetings should be continued to accomplish the following objectives:

(1) To understand the viewpoints which in the past, has created a schism between medical educators and the medical profession. In other words an intensification of the old "Town and Gown" attitude.

(2) To keep up constant communication between the educators and organized medicine.

(3) To keep abreast of the need for more physicians and paramedical personnel. Georgia's exploding population needs, today, far more facilities than are presently available, for the education and training of physicians, nurses and other paramedical personnel. It is the duty of organized medicine to keep these problems before the public and the various governmental officials of the state and local governments.

Another problem is the tremendous public interest created in the field of mental health, with the attendant problems of treatment and prevention of mental illness. Since all of these problems are usually cared for by physicians, either early or late, it is imperative that organized medicine understand and continue to care for such problems. The rights and privileges of the individual receiving such treatment must be preserved.

Again I wish to express my appreciation for being permitted to serve you.

**REFERENCE COMMITTEE RECOMMENDATION**—This committee received and reviewed the report of the Immediate Past President and recommended approval of this report with amendment. This committee recommends that the honorarium of the President be increased to \$2,400.00 plus expenses, which are already being reimbursed by MAG. This is a decrease from the \$5,000.00 recommended by the Immediate Past President, and an increase from the \$1,000.00 now being paid for honorarium to the President.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Immediate Past President as amended by the Reference Committee on motion duly made and seconded.

**First Vice President**

JOHN KIRK TRAIN, M.D., *Savannah*

The past twelve months have been active ones for the First Vice President, each month producing some form of travel to either Executive Committee meetings, Council meetings, or Special meetings. All monthly Executive Committee meetings with the exception of two have been attended, and all Quarterly Council meetings with the exception of one have been attended. In addition there was a trip to Atlanta to attend the

meeting of Council's Special Ad-Hoc committee, to study the transfer of non-psychotic elderly patients from the Milledgeville State Hospital to nursing homes or other facilities in the state. There were also two trips to Washington on MAG business, one during the past summer, with a group of other MAG members to meet with Senator Russell, and express to him the Association's views on the medicare legislation then pending, and one to attend the luncheon given annually by MAG to meet with our Congressmen and to discuss matters of mutual interest.

I appreciate greatly the chance of having been Vice President of this organization.

**REFERENCE COMMITTEE RECOMMENDATION**—The report of the First Vice President was received and reviewed by this committee with approval and commendation of this report. The committee would like to emphasize the recommendation to transfer nonpsychotic elderly patients from Milledgeville State Hospital to nursing homes.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the First Vice President as recommended by the Reference Committee on motion duly made and seconded.

**Second Vice President**

HENRY S. JENNINGS, JR., M.D., *Gainesville*

Your Second Vice-President has attended meetings of Council and has been privileged to become better acquainted with the other officers and members of the Council and to observe more of the mechanism of administration of the MAG. This acquaintance and observation has brought about the profoundest respect for these men and the work they do.

In order to give more members of MAG the opportunity to understand better the organization, efforts, and activities of the Association perhaps the Council might wish to invite, as observers only, the Delegates residing in or near the cities chosen for the quarterly Council meetings.

**REFERENCE COMMITTEE RECOMMENDATION**—The report of the Second Vice President was reviewed by this committee and was approved with commendation. The committee particularly favors the recommendation that the delegates of societies be invited to Council meetings in their immediate area in order to help combat the present apathy of some members toward knowledge of the organization of MAG.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Second Vice President as recommended by the Reference Committee with the additional recommendations made by the Reference Committee on motion duly made and seconded.

**Secretary**

JOHN T. MAULDIN, M.D., *Atlanta*

This has been a very active and progressive year for the Medical Association of Georgia. Political education activities reached a peek during the election. GaMPAC was very active and it is strongly recommended that this organization be strengthened and backed during the off year.

The problem of medical ethics seems to be on the increase, partially the relation between the individual physician, hospital staffs, and committees. The authority and scope of the Medical Ethics Committee has not been changed in a number of years. It is recommended that the House of Delegates instruct the Council of the Medical Association of Georgia to investigate this matter, make any needed changes within its jurisdiction and report the results to the House of Delegates.

MEDICARE

Dr. R. C. William's resignation as Director of Medicare was accepted with regrets in January, 1965. Mrs. Joyce Butler was appointed as Director. The contract with the Department of Army was renewed without major change.

The following is the statistical report of the Medicare Department of the Medical Association of Georgia.

Number of Claims received . . . . .	14,632	
Number of Claims returned . . . . .	2,883	12%
Number of Claims paid . . . . .	11,192	77%
Number of Claims rejected . . . . .	282	2%
Number of Claims Adjudicated . . . . .	230	2%
Total Amount Paid . . . . .	\$921,798.69	
Average payment per claim . . . . .	82.36	
Average Number of claims processed per day . . . . .	55.4	

This is compared to 10,610 claims paid in 1963 at a total dollar value of \$864,648.37.

HOSPITAL MEDICAL COUNCIL

This has been a very active year for the Council and a report on Council activity is made by Dr. Charles Cowart of LaGrange, who has acted as Chairman during the year. This report is included under Dr. Cowart's report to the Council.

ADULT RECIPIENT PROGRAM

The Medical Association of Georgia has continued to operate the evaluation portion of the Kerr-Mills program under contract with the Department of Family and Children Services of the State of Georgia. There have been no changes in the program during the year.

The following is the statistical report of the program's activities:

Hospital Claims Received . . . . .	25,266	
Returned for Additional Information . . . . .	1,453	
Total . . . . .	26,719	
Requests for Extension . . . . .	3,885	
Total Rejected Claims . . . . .	349	
Total Amount Paid by the Dept. of Family & Children Services for Hospital Care . . . . .	\$4,812,768.52	

HEADQUARTERS OFFICE

As Secretary, I have coordinated the administrative problems of the Headquarters Office and handled the

correspondence related to medical policy not within the jurisdiction of other officers and committees. The Headquarters Office has functioned well and has been most cooperative due to the foresight and excellent judgment of the Executive Staff. Mr. Milton Krueger, the Executive Secretary, Mr. Jim Moffett, the Assistant Executive Secretary, and Mrs. Catherine Wooten, Assistant Executive Secretary have been most cooperative and deserve commendation for service beyond the call of duty.

HEADQUARTERS OFFICE BUILDING

The Headquarters Office Building has been used at least twice a week as a meeting place for MAG and allied organizations. No major repairs or changes have been necessary during the past year.

MAG MEMBERSHIP

Active	2,841
Active dues exempt	325
Service members	59
Associate members	35
TOTAL	3,260

I wish to express my appreciation for the cooperation of the Officers and members of the Medical Association of Georgia, particularly to thank the members of the Medical Association for their understanding and patience in supplying necessary information and proper information to expedite the medical care program now being administered by the Medical Association of Georgia.

**REFERENCE COMMITTEE RECOMMENDATION**—The report of the Secretary was received and reviewed by this Reference Committee and we recommend approval with commendation. This committee strongly urges the House of Delegates to instruct the Council of the Medical Association of Georgia to investigate the matter of medical ethics in Georgia, and augment the efforts of the Medical Ethics Committee.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Secretary as recommended by the Reference Committee with the additional recommendations made by the Reference Committee on motion duly made and seconded.

Treasurer

JOHN S. ATWATER, M.D., *Atlanta*

The report of the auditors, Ernest and Ernst, is attached. This audit covers the period ending the calendar year December 31, 1964. It is to be pointed out that the Association is in good financial condition, in fact, the best position in many years. While the overhead expenses have increased there has also been an increase in income sufficient to meet these obligations.

I should like to thank most sincerely all those who have had a part in the conduct of the office of the Treasurer and especially our most efficient bookkeeper, Miss Thelma Franklin.



# ERNST & ERNST

FIRST NATIONAL BANK BUILDING

ATLANTA, GA 30303

Chairman of the Council  
The Medical Association of Georgia  
Atlanta, Georgia

We have examined the statement of assets and liabilities of the several funds of The Medical Association of Georgia as of December 31, 1964, and the related statements of income and expenses and fund equities for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. While it was not practicable to confirm the amount due from the United States Government with respect to the Medicare Fund, we have satisfied ourselves as to this balance by means of other auditing procedures.

In our opinion, the accompanying statement of assets and liabilities and the statements of income and expenses and fund equities present fairly the financial position of the several funds of The Medical Association of Georgia at December 31, 1964, and the results of operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Atlanta, Georgia  
February 18, 1965

*Ernst & Ernst*

## STATEMENT OF ASSETS AND LIABILITIES — BY FUNDS

The Medical Association of Georgia

December 31, 1964

### ASSETS

#### GENERAL FUND

Cash:			
Demand deposits . . . . .		\$ 450.49	
Savings deposits:			
Restricted . . . . .	\$ 9,098.85		
Unrestricted . . . . .	70,000.00	79,098.85	\$ 79,549.34
Accounts receivable:			
Advertisers of The Journal . . . . .		\$ 2,304.66	
Due from Old Age Assistance Program . . . . .		772.34	
Excess of claim expenses over claim fees received — United States Government — Medicare . . . . .		2,126.61	5,203.61
Other assets . . . . .			625.00
Property and equipment — on the basis of cost:			
Buildings — mortgaged . . . . .	\$ 94,454.72		
Furniture and equipment . . . . .	26,227.50		
	\$120,682.22		
Less allowances for depreciation . . . . .	43,267.18		
	\$ 77,415.04		
Land — mortgaged . . . . .	80,000.00		157,415.04
			\$242,792.99

#### ABNER W. CALHOUN LECTURESHIP FUND

Cash . . . . .	\$ 135.96		
Corporation stocks (quoted market prices \$5,607.63) — at cost . . . . .	5,897.03		6,032.99

#### MEDICARE FUND — DEPARTMENT OF THE ARMY

Cash . . . . .	\$ 23,050.35		
Due from United States Government — service fees paid to physicians and dentists . . . . .	76,949.65		100,000.00
			<u>\$348,825.98</u>

### LIABILITIES AND EQUITIES

#### GENERAL FUND

Liabilities:			
Note payable to insurance company, \$4,000.00 installment, with interest at 5%, due on January 1, each year — secured by loan deed on land an building . . . . .			\$ 15,000.00
Advance collections:			
1965 membership dues . . . . .	\$ 1,211.00		

1965 exhibit space payments . . . . .	4,725.00	5,936.00
Fund equity:		
Restricted:		
Regular operating purposes . . . . .	\$ 20,000.00	
Lecture expenses . . . . .	412.15	
	<u>\$ 20,412.15</u>	
Unrestricted . . . . .	201,444.84	221,856.99
		<u>\$242,792.99</u>
<b>ABNER W. CALHOUN LECTURESHIP FUND EQUITY</b>		6,032.99
<b>MEDICARE FUND — DEPARTMENT OF THE ARMY</b>		
Advance from United States Government . . . . .		100,000.00
		<u>\$348,825.98</u>

## STATEMENT OF FUND EQUITIES

The Medical Association of Georgia  
Year ended December 31, 1964

	Balance Jan. 1, 1964	Ad Valorem Property Taxes	Adjusted Balance Jan. 1, 1964	Income in Excess of Expenses	Fund Transfers	Balance Dec. 31, 1964
<b>GENERAL FUND</b>						
Restricted for operating purposes . . . . .	\$ 20,000.00	\$ -O-	\$ 20,000.00	\$ -O-	\$ -O-	\$ 20,000.00
Restricted for lecture expenses . . . . .	172.14	-O-	172.14	-O-	240.01	412.15
Unrestricted . . . . .	<u>208,218.75</u>	<u>7,689.39(A)</u>	<u>200,529.37</u>	<u>915.47</u>	<u>-O-</u>	<u>201,444.84</u>
	<u>\$228,390.89</u>	<u>\$7,689.38</u>	<u>\$220,701.51</u>	<u>\$ 915.47</u>	<u>\$240.01</u>	<u>\$221,856.99</u>
<b>ABNER W. CALHOUN LECTURESHIP FUND</b>	6,032.75	-O-	6,032.74	240.26	240.01*	6,032.99
<b>TOTAL</b>	<u>234,423.63</u>	<u>\$7,689.38</u>	<u>\$226,734.25</u>	<u>\$1,155.73</u>	<u>\$ -O-</u>	<u>\$227,889.98</u>

\*Indicates red figure.

(A) During 1964 the Association settled previously contested assessments for ad valorem property taxes for the years 1960 through 1964. That portion of the settlement applicable to prior years (\$7,689.38) was charged to the unrestricted portion of the General Fund Equity as of January 1, 1964, and the balance (\$1,922.34) was charged to Association Office expenses for the year.

## STATEMENT OF INCOME AND EXPENSES — BY FUNDS

The Medical Association of Georgia  
Year ended December 31, 1964

	General Fund	Abner W. Calhoun Lectureship Fund
<b>INCOME</b>		
Medical Association of Georgia dues . . . . .	\$113,615.00	\$ -O-
Advertising — The Journal . . . . .	29,561.62	-O-
Subscriptions — The Journal . . . . .	1,081.60	-O-
Exhibitors' fees — 1964 annual meeting . . . . .	6,925.00	-O-



Interest income . . . . .	4,057.50	-0-
Dividends — corporate stocks . . . . .	-0-	263.42
American Medical Association refund . . . . .	1,222.01	-0-
Miscellaneous . . . . .	29.39	-0-
<b>TOTAL INCOME</b>	<b>\$156,492.12</b>	<b>\$263.42</b>
<b>EXPENSES</b>		
Fixed allotments . . . . .	\$ 9,958.95	\$ -0-
Association office — Note . . . . .	86,016.21	-0-
Association boards . . . . .	14,983.05	-0-
Related Association activities . . . . .	1,840.88	-0-
Contingent fund . . . . .	2,389.15	-0-
The Journal . . . . .	40,388.41	-0-
Trustees fees and expenses . . . . .	-0-	23.16
<b>TOTAL EXPENSES</b>	<b>\$155,576.65</b>	<b>\$ 23.16</b>
<b>EXCESS OF INCOME OVER EXPENSES</b>	<b>\$ 915.47</b>	<b>\$240.26</b>

See Note to Statement of Fund Equities.

**REFERENCE COMMITTEE RECOMMENDATION**—The Treasurer's report was received and reviewed by this committee and was approved with commendation.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Treasurer as recommended by the Reference Committee on motion duly made and seconded.

**Speaker, House of Delegates**  
J. FRANK WALKER, M.D., *Atlanta*

The response to the innovations instituted in the House of Delegates during my several years as Speaker has been gratifying. This year, again, changes have been made in an attempt to increase the effectiveness and efficiency of the House. Comments pro and con will be appreciated.

Your Speaker reminds the County Medical Societies to continue to select knowledgeable physicians as Delegates to the Medical Association of Georgia—Delegates who will attend and participate in the deliberations. Delegates should not ignore the more important second session of the House of Delegates, where voting on the issues is accomplished. It is still a matter of concern that several of the important small counties, each year, do not avail themselves of representation in the House of Delegates.

All physicians, Delegates or not, have an obligation to attend the meetings of the various Reference Committees, when they are knowledgeable of the subjects at issue.

The ultimate authority of the Medical Association of Georgia rests with the House of Delegates, and your Speaker and Vice-Speaker represents you at the meetings of the MAG Council. The actions of this House, after study, are referred for action to the appropriate individual or group; and the proposals are reviewed during the year to determine whether or not the wishes of the House are being accomplished.

Your Speaker feels a deep sense of personal loss in the death of Vice-Speaker Joe Mercer. The Mayor of Brunswick was killed in an automobile accident while traveling, in his official capacity as an official of this House, to a MAG Council meeting in Albany. The Medical Association of Georgia has lost a dedicated leader, a man of courage, vision, conviction and unlimited potentialities.

**REFERENCE COMMITTEE RECOMMENDATION**—The report of the Speaker of the House was received, reviewed and approved with commendation. This committee would like to emphasize two items in this report. There is a need for a more active participation to combat the apathy of the county medical societies and the participation of delegates at meetings. Also we would like to underscore this committee's deep regret at the loss of Vice Speaker Joe Mercer in his untimely death by automobile accident.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Speaker of the House as recommended by the Reference Committee with the additional recommendations made by the Reference Committee on motion duly made and seconded.

**Medical Defense Subcommittee**  
CHARLES S. JONES, M.D., *Chairman*

The past year has been another successful one for the Professional Liability Program of the Medical Association of Georgia. As a result of this, the St. Paul Companies, our insurance carrier, has announced a premium rate reduction across-the-board. The amount of this reduction is modest. However, when one compares our present rate with that available in the open market, it is apparent that this cooperative effort has saved the doctors of Georgia several hundred thousand dollars over the past few years. For the purpose of comparison there is shown a table listing the new St. Paul rates, the "standard rates" for professional liability insurance in its various categories.

	<i>MAG Rate</i>	<i>Standard Rate</i>
Group I	\$30	\$ 43
Group II	\$36	\$ 54
Group III	\$84	\$103
Group IV	\$84	\$155

These rates are for basic coverage of 10 and 15 thousand dollars. To convert this to 100 and 300 thousand multiply the basic rate by 2.6.

It might be of interest to some that the St. Paul Companies have made available an "Excess Limits" policy which covers in amounts up to one million dollars for various liabilities. For those who are interested in such coverage it would be worthwhile to contact your local St. Paul agent.



**REFERENCE COMMITTEE RECOMMENDATION**—The Medical Defense Subcommittee report was received and reviewed by this committee. We approve this report with commendation. As a point of interest, there is a notation that there is available an excess limits policy, which covers in amounts up to one million dollars for various liabilities, by the St. Paul Company.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Medical Defense Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

## Medical Education

THOMAS W. GOODWIN, M.D., *Chairman*

This committee has been very active during this past year, and it is felt that much progress has been made in some of the fields in which this committee operates. An organizational meeting of this committee was first held in Atlanta and was followed by three later meetings in 1964. At these meetings representatives from the medical schools and the MAG were present, and it was decided to have a Georgia Conference on Medical Education and to invite certain representative members of the MAG and the two medical schools in order to participate in the discussions. It was finally decided that this meeting would be held at Callaway Gardens on January 29, 30, 31, 1965. Those of you who were present will remember that a great deal of discussion took place on several important subjects and that much progress was made along certain lines. For those of you who could not attend, briefly this meeting was set up to include fifteen representatives from the teaching faculties from each one of the medical schools and approximately thirty representatives from the MAG.

During the course of the discussions at Callaway Gardens five broad subjects were pursued. (1) The "town and gown" syndrome, (2) The question of undergraduate medical education, (3) The problem of communication between the medical schools and the medical practitioners in the state, (4) Continuing postgraduate medical education, and (5) The possibility of establishing postgraduate residences at non-university hospitals to train general practitioners. These discussions consumed the better part of two days and, as noted above, it was felt that considerable progress was made in certain of these fields.

As a follow-up, another meeting of the Board of Medical Education was held at Macon, Georgia, on March 7, 1965. At that time representatives from the Georgia Academy of General Practice and other general practitioners in the state were present, and also certain selected hospital administrators. At this meeting the board concerned itself with only two of the five subjects listed above; namely, that of continuing postgraduate medical education and the possibility of establishing general practice postgraduate residence at some of the non-university hospitals throughout the state. Representatives from the Medical College of Georgia were present and the problem of continuing postgraduate education was discussed. It was pointed out that some postgraduate courses are now being planned by both medical schools and that some actually have been held. The general conclusion of the meeting was that in the field of graduate medical education the medical schools and the medical profession needed to consolidate meetings, cooperate in cosponsorship of meetings, and communicate with each other so that the members of the profession for whom these meetings are designed know about the meetings and can avoid duplication of meetings. The establishment of so-called

"circuit courses" over the state in at least six regional centers was discussed and will be implemented during the next year. Adequate notice of the time and location of these meetings will be given to the medical profession.

In so far as establishing general practice residency programs in non-university hospitals is concerned, it was decided a thorough discussion that the first and most important activity in this regard should be the filling up of the existing general practice residencies which already exist in Georgia. It also was felt that after this is accomplished, the MAG should concern itself by getting a few more hospitals interested in such a program. It also was recommended that the Association seek to promote the status of the general practitioner with his own colleagues as well as those in the specialty fields, and that some extra effort should be made by the medical schools to tell their students about the existing residency programs in general practice in Georgia. It also was suggested that certain recognition be given to qualified general practitioners for staff privileges after completing such a residency program, and that the MAG should use its moral persuasion in this respect. Too, it was felt that these residency programs for general practitioners should provide two additional years' training beyond the internship, but it was agreed also that the program should be flexible to meet the needs of the doctors of Georgia. The general practice residency programs at the Macon General Hospital and at the Medical Center in Columbus were discussed in detail.

The Medical Education Board hopes during the coming year to implement some of these suggestions. We hope to see the so-called "circuit courses" in the field of continuing postgraduate medical education really started, and that such programs will be of benefit to all of the practitioners in Georgia. If and when the time arises, we also have plans to contact the Archibald Memorial Hospital in Thomasville in regard to establishing a third general practice residency in the state.

Let me take this opportunity to thank all members of the committee who have been so generous in giving their time to the problems of the committee, and let me assure you that the committee will continue to work through the next year in an effort to advance medical education in this state in all of its phases.

**REFERENCE COMMITTEE RECOMMENDATION**—The report of the Medical Education Board was received and reviewed by this Reference Committee and we recommend approval with commendation. This board should be commended and encouraged to continue their efforts for continuing improvement of medical education in both graduate and postgraduate areas.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Medical Education Board as recommended by the Reference Committee with the additional recommendations made by the Reference Committee on motion duly made and seconded.

## Occupational Health

T. A. PETERSON, M.D., *Chairman*

As Chairman of this Board I represented the State of Georgia at the annual AMA Congress on Occupational Health in Houston, Texas, in September, 1964.

**REFERENCE COMMITTEE RECOMMENDATION** — Occupational Health Board report was received and was approved by this Reference Committee.



**HOUSE OF DELEGATES ACTION**—Adopted the report of the Occupational Health Board as recommended by the Reference Committee on motion duly made and seconded.

## **Resolution No. 6**

### **FIREPROOFING FOR CLOTHING**

**JAMES M. SKINNER**

#### **FOR SPALDING COUNTY MEDICAL SOCIETY**

WHEREAS, there is an increasing number of children who receive burns as the result of highly inflammable garments, and

WHEREAS, the material used for the manufacture of some garments burns at great intensity and rapidity, and

WHEREAS, a method of chemical impregnation with the fire resistant material on this material would not be too costly and

BE IT RESOLVED that the MAG instruct the delegate to the AMA to present a resolution recommending that all materials that are used in the manufacture of clothing which are inflammable and burn with ease and intensity, be impregnated with a fire resistant type of chemical to protect the children and adults from the increased incidence of burns due to clothing catching on fire.

**REFERENCE COMMITTEE RECOMMENDATION**—Resolution No. 6 was read and approved by this committee.

**HOUSE OF DELEGATES ACTION**—Adopted Resolution No. 6: Fireproofing for Clothing as recommended by the Reference Committee on motion duly made and seconded.

It was moved by Reference Committee No. 1, Chairman J. H. Beall, Carrollton, and duly seconded that the report of the Reference Committee be approved as a whole and it was so ordered.

## **Report of Reference Committee No. 2**

**Harrison Rogers, Atlanta, Chairman**

*(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)*

Reference Committee No. 2 met in the Embassy Room of the Augusta Town House Motor Hotel, Augusta, Georgia, at 2:30 p.m., May 3, 1965. Members present were: Harrison Rogers, Atlanta, Chairman; C. A. Wilson, Brunswick, Vice Chairman; A. G. LeRoy, Thomson, Secretary; C. J. Roper, Jasper; A. G. Funderburke, Moultrie; Robert P. Coggins, Marietta; R. D. Waller, Albany; Fenwick Nichols, Savannah; and A. Jack Waters, Augusta.

### **Council of MAG**

**ADDISON W. SIMPSON, JR., M.D., Chairman**

The year 1964-65 has been a busy one for Council and at this time, I would like to thank all the officers, members of Council, Committees, and the Headquarters Staff for their wonderful cooperation so unselfishly given.

Special commendation is due our Treasurer, the Finance Committee, and our Secretary, for the unselfish devotion to duty, as evidenced by the long hours of work and the excellent results achieved.

Council was extremely saddened by the news of the death of Dr. Joe Mercer, who died while in route to an MAG Council meeting. A telegram was immediately sent to his family expressing our grief over the news of his tragic and untimely passing.

This review of the year's activities will be given as briefly as possible, and it is suggested that where points of particular interest arise, that the minutes of Council be consulted.

At the organizational meeting, which immediately followed the 1964 Annual Session in Macon, the following officers were elected: Dr. Addison W. Simpson, Chairman; Dr. Walter Brown, Vice Chairman; Dr. Edgar Woody, Editor of JMAG; Dr. Charles Andrews was appointed Chairman of the Finance Committee; Dr. John Atwater was appointed Treasurer; Mr. Milton Krueger was selected as Executive Secretary.

The following is a numerical listing of some of the highlights of actions taken by the Council during the past year. Many of these actions are reported in detail by the Board of Subcommittee having primary jurisdiction over the matter in question. Many of the actions were finalized by Council and will not appear in any other report in this Handbook.

1. Council approved appointments to all MAG Boards and Committees at its June 1964 meeting. At this meeting Council also approved a motion that henceforth all speeches by incoming MAG Presidents would be referred to a reference committee of the House of Delegates.

2. Council approved a motion that upon the future recommendation of the Finance Committee, the MAG President would be given funds to attend out-of-state meetings and certain in-state meetings, other than meetings of the Council and the Annual Session.

3. The matter of repackaging drug houses and physician ownership, or financial interest in such commercial establishments, was clarified per letter published in the JMAG and the Officer's Newsletter.

4. The Council approved nominees to the State Board of Health as received from medical society districts 3, 4, and 7. This was done pursuant to the provisions of the new Georgia Health Code in which all health laws were recodified.

5. A glaucoma screening project to be conducted by the Georgia State Department of Public Health was approved by Council.

6. Council approved MAG participation in the Atlanta Consumer's Conference sponsored by the Federal Government in October 1964.

7. Council requested the MAG President to attend the AMA Public Relations Conference in Chicago in August 1964.

8. Council directed MAG to support an increase in State appropriations for additional State Highway Patrolmen to help reduce the incidence of traffic injuries.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee approved items 1 through 8 on the report of Council.

**HOUSE OF DELEGATES ACTION**—Adopted that portion of the report of Council including items 1 through 8 as recommended by the Reference Committee on motion duly made and seconded.



9. Council adopted a resolution asking the legislature to enact a law to re-examine persons over age 55 who are applicants for a driver's license and that such re-examination would consist of a simple physical examination to be given by State troopers.

**REFERENCE COMMITTEE RECOMMENDATION**—With regard to item 9, the Committee accepts with approval with the following recommendations for change, advising the deletion of the last phrase under the section, so that the final report will read: "Council adopted a resolution asking the legislature to enact a law to re-examine persons over age 55 who are applicants for a driver's license."

**HOUSE OF DELEGATES ACTION**—Adopted that portion of the Council report included in item 9 as amended by the Reference Committee on motion duly made and seconded.

10. Council approved a conference on medical education in conjunction with Georgia's two medical schools.

11. Council approved a resolution stating that the National Association of Practical Nurses Education and Service (NAPNES) continue its accreditation of schools for practical nursing.

**REFERENCE COMMITTEE RECOMMENDATION**—Items number 10 and 11 are approved.

**HOUSE OF DELEGATES ACTION**—Adopted that portion of the report of Council including items 10 and 11, as recommended by the Reference Committee on motion duly made and seconded.

12. Council approved redistricting of Councilor Districts along Congressional District lines, and that existing local county societies divided by such Congressional District lines be allowed to choose with which Councilor District they will affiliate.

**REFERENCE COMMITTEE RECOMMENDATION**—Concerning item number 12 in the Council report, the Committee approved the Council's action with the following recommendations to be added to this item: That the redistricting become effective January 1, 1966, but that the Councilors and Vice Councilors now in office remain in office until the Annual Meeting of the Medical Association of Georgia in 1966.

**HOUSE OF DELEGATES ACTION**—Adopted that portion of the Council report included in item number 12 as recommended by the Reference Committee with the additional recommendation made by the Reference Committee on motion duly made and seconded.

13. Council approved a liaison meeting of the MAG Executive Committee and the newly appointed members of the State Board of Health.

**REFERENCE COMMITTEE RECOMMENDATION**—Item number 13 of the Council report approved.

**HOUSE OF DELEGATES ACTION**—Adopted that portion of the report of Council included in item number 13, as recommended by the Reference Committee on motion duly made and seconded.

14. The Relative Value Study Committee report was received by Council, but Council recommended to the MAG House of Delegates approval of the 1964 revision of the California Relative Value Study Schedule for the MAG with changes in the preamble to all sections and with a revision of the radio isotopes section. Council further approved the method of transmission of this data, which was to be, that a copy be sent to each medical society President and Secretary, each delegate and member of Council.

**REFERENCE COMMITTEE RECOMMENDATION**—Concerning item number 14 of the Council report, the Reference Committee reviewed the available information and heard from numerous delegates on this most important report. The Reference Com-

mittee would like to commend the long and diligent labors of the Relative Value Study Subcommittee for a job very well done. There was a tremendous variation in the feelings of the committee members, and of all those who testified, and it was the conclusion of the Reference Committee that this report should be received for information. All members of the Medical Association of Georgia must be given this information prior to a decision being reached by the House of Delegates of MAG. It is advised that all MAG members be furnished with this information in as detailed a fashion as possible and with the greatest possible speed. It is further recommended that the Relative Value Study Committee include in the information sent to the membership changes in the preamble of the California Relative Value Schedule (1964) as submitted to the Committee and which are attached as a separate enclosure to this report (See "Addendum to Reference Committee No. 2 Report—Relative Value Study"). It is finally recommended that after study by all members of the MAG during the ensuing months, that this measure be voted on by the House of Delegates in 1966. Your Reference Committee feels that this is of sufficient importance and complexity to warrant that at the Delegates meeting in 1966, this matter be referred to a special Reference Committee to which no other business be assigned.

(The following addendum to Reference Committee No. 2 Report—Relative Value Study as referred to in the Reference Committee Recommendation above is printed hereinafter):

**Addendum to Reference Committee No. 2 Report  
Relative Value Study Preamble**

Basically, there are two methods whereby "third parties" may assist individuals in paying for their health related expenses—the indemnity method and the service contract method. In assisting non-medical personnel to administer both types of methods it is recognized that a relative value schedule of medical services would be valuable.

The medical profession feels that the development of indemnity type insurance programs is of great value to the public and wishes to encourage and cooperate with this development. It is further recognized that a number of service contract programs, primarily administered by governmental bureaus are in existence. Where these programs are based on a definite financial need of the parties to be served, the medical profession has always provided medical care at no cost or on a reduced fee basis. This principle is endorsed again at this time.

This Relative Value Schedule is intended for the following purposes:

(1) To assist administrators of service contract type programs, within the definition outlined above, to negotiate with the medical profession through the Medical Association of Georgia for the fee schedule applicable to their particular program. It is recognized that such a negotiation would be greatly simplified by the necessity of arriving at agreement on only four "conversion factors." It is further recognized that the acceptance by a physician of a patient under one of these programs would be purely voluntary.

(2) To assist the insurance carrier in preparing his indemnity table for coverage provided in a more realistic manner insofar as the relative values of these items are concerned.

This Relative Value Schedule is NOT intended to act as the basis for establishing a Fee Schedule. The immense complexity of human illness and other health care needs, as well as the varying degrees of knowledge and skill brought by different physicians to the care and treatment of these problems makes a rigid fee schedule both impractical and impossible. The compliance of individual physicians to the relative values outlines in this schedule is optional.

**HOUSE OF DELEGATES ACTION**—At this point, Speaker Walker recognized William Dowda, Atlanta, who presented the following substitute motion for the Reference Committee Recommendation:

On motion (William Dowda-Joe Wilson), The House of Delegates commends the Relative Value Subcommittee for the amount of work done in preparing the Relative Value Schedule and hereby creates a negotiating committee to be composed of the duly elected negotiating representatives of all the specialty and subspecialty groups (this is intended to include the Georgia Academy of General Practice). These representatives to be elected by their specialty or subspecialty group and to have the authority to negotiate with third parties a fee schedule for their specialty or subspecialty—such fee schedules being subject to final approval by the Council of MAG. To aid in this committee deliberation the House of Delegates refers the current Relative Value Schedule (California 1964) and makes mandatory the review of this Relative Value Schedule every three years, and makes mandatory the review of a specialty or subspecialty's Relative Value Schedule upon receipt of a petition signed by more than 50% of the participating members of a specialty or subspecialty. This is of sufficient importance and complexity to warrant that at the Delegates meeting in 1966, this matter be referred to a special Reference Committee to which no other business be assigned.

Speaker Walker then recognized various delegates speaking in favor and in opposition of the substitute motion to the Refer-



ence Committee Recommendation on item 14 in the Council report. After due discussion, a vote was called and the Dowda-Wilson substitute motion to the Reference Committee Recommendation on item 14 was approved.

Speaker Walker then recognized Robert Wells of Atlanta, who discussed the previous action on the substitute motion for the Reference Committee Recommendation on item 14. Dr. Wells moved that the preamble referred to as the "Addendum to Reference Committee No. 2 Report—Relative Value Study Preamble" be adopted, but this motion was ruled out-of-order, as the preamble would be referred to the negotiating committee along with the California Relative Value Schedule of 1934 per the Dowda-Wilson substitute motion which carried.

15. Council approved a renegotiation of the schedule of fees of the Veterans Administration.

16. Council approved the installation of a teletype communications system linking MAG with AMA and the headquarters of all other participating State Medical Associations. This system was installed and is maintained at AMA's expense.

17. Council approved an Interprofessional Council of Georgia resolution whereby pharmacists would be included among the planners for the mental health program in Georgia being developed by the Mental Health Division of the State Department of Public Health.

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee recommends approval of items 15, 16 and 17 as stipulated in the report of Council.

**HOUSE OF DELEGATES ACTION**—Adopted that portion of the Council report including items 15, 16 and 17, as recommended by the Reference Committee on motion duly made and seconded.

18. Council approved the revision and streamlining of the MAG Annual Session, whereby the State meeting was shortened by one day, in an effort to make the Annual Session more attractive to a greater number of physicians.

**REFERENCE COMMITTEE RECOMMENDATION**—Concerning item 18 in the Council report, the Reference Committee recommends approval with commendation.

**HOUSE OF DELEGATES ACTION**—Adopted that portion of the Council report included in item 18 as recommended by the Reference Committee on motion duly made and seconded.

19. Council gave great attention to and approved the campaign to fight enactment of so-called "medicare" by the Congress.

20. Council approved the appointment of an ad hoc committee to study and make recommendations on the transfer of non-psychotic patients from the Milledgeville State Hospital to nursing homes, so that patients might come under the provisions of the Kerr-Mills program.

21. Council approved a one day legislative conference in January 1965, to take the place of the regular county society officers conference usually held in February. This was done in response to the critical legislative situation in Washington.

22. Council approved a revamping of State's marriage laws with a three day waiting period and parental consent to be an integral part of such recamping legislation. Council also approved in principle a voluntary sterilization bill.

23. Council gave its approval to an oral cytology program proposed by the State Department of Public Health.

24. The Council approved a visitation program of MAG Officers with the Georgia Governor regarding the implementation of MAA under Kerr-Mills.

**REFERENCE COMMITTEE RECOMMENDATION**—Concerning items 19 through 24, the Reference Committee recommends approval.

**HOUSE OF DELEGATES ACTION**—Adopted that portion of the report of Council including items 19 through 24, as recommended by the Reference Committee on motion duly made and seconded.

25. Council approved the MAG Mental Health Subcommittee recommendations with additional recommendations of its own which appear below italicized:

The Medical Association of Georgia Subcommittee on Mental Health after due study and deliberation recommends to the MAG Council for consideration and approval the full endorsement and support of Local Mental Health Centers on the basis of the following principles:

(1) That the Medical Association of Georgia goes on record as committing the Association's cooperation in stimulating the staffing of community mental health programs. It is emphasized that the basic concept of local mental health programs must involve both psychiatric and non-psychiatric physicians in a position of leadership if the community mental health programs are to succeed. At the present time, both psychiatric and non-psychiatric physicians are only partially involved in the treatment of the mentally ill at the local level. Our subcommittee believes that the private practice of medicine must meet this responsibility at the local level in the community so that the psychiatrically ill patient will not be passed on to the most impersonal type care given by our large state institutions for the mentally ill.

(2) That the Medical Association of Georgia through its component county medical societies exert its influence upon local or community governments to assure some financial responsibility in the establishment of local mental health programs. Local levels of government have up to this time been quite delinquent in supplying funds for the care of the mentally ill at the community level. It is the recommendation of this subcommittee that local governments must begin to appropriate funds for local mental health programs — and along with the financial assistance of the state and federal governments, community health programs can be amply financed. The advantage of the participation of local government is obvious in that the local mental health program can then be "tailored" to suite the needs of the individual community and the program then in fact becomes a local program.

(3) That the Medical Association of Georgia recognize the problem of patient eligibility for care at a local mental health center as may be different from the traditional concept of indigency or medically indigency care. Three factors must be emphasized as the basis for this differentiation: (1) that mentally ill patients frequently lack insurance coverage; (2) that treatment of a long duration may be required; (3) and that the availability of such treatment can be a real problem. Therefore, the subcommittee recommends that a different "yardstick" for eligibility be used and that the term "psychiatric-indigency" be employed to distinguish from other types of health care indigency. The subcommittee believes that the patient eligibility for care in local mental health programs should be set on the basis of an economic yardstick to include the total or partial psychiatrically indigent patient.

(4) That the Medical Association of Georgia recommends the principle of a "patient part-pay" schedule



for local mental health programs. The subcommittee recommends that each community mental health program seek to establish as a guideline some type of "pay or part-pay" schedule for psychiatrically indigent patients treated in community mental health centers. The subcommittee believes this concept important in that it would provide for the patient responsibility aspect of medical care and at the same time lend some financial support to maintaining such programs. Such requirements and pay schedules will, by necessity, differ from community to community. For example, such a patient pay schedule is attached to this report. It is based on the number of dependents and has been effective in one community. This schedule is attached as a guideline only and it must be understood that this type of schedule will vary from one community to another.

(5) That the Medical Association of Georgia subscribe to the concept that physicians under certain circumstances will by necessity have to be reimbursed for patient care rendered in a community health program. There are presently available formulas through the State Health Department for pay to physicians; i.e., the Crippled Children's Program, etc., which may be used as guidelines. These formulas might well be adjusted and the method and amount of payment be determined totally as the special needs of the community dictate. It must be emphasized again that such a concept will vary from one community to another depending solely on local factors.

(6) That the Medical Association of Georgia recommends that there be established a professional Board to include representatives from the local county medical societies, local health officer, Medical Association of Georgia, Georgia Psychiatric Association, and the Department of Public Health. The purpose of this Board is to have authority to "tailor" individual programs to meet the special needs of specific areas where mental health programs are to be established.

Finance

CHARLES R. ANDREWS, JR., M.D., *Chairman*

The Finance Committee is composed of Dr. C. E. Bohler, Dr. Frank McKemie, and the Chairman. An annual meeting of Finance Committee held November 22, 1964 at MAG Headquarters. Also attending were Dr. J. G. McDaniel, Dr. John Atwater, Dr. George Alexander, as well as Mr. Milton Krueger, and Miss

(7) That the Medical Association of Georgia recommends the concept that patients be accepted at the regional treatment centers for examination and/or treatment only when referred by a doctor of medicine who may be the regional or local health officer. Exceptions to such plan will be the responsibility of the local Professional Board.

(8) *Council should recommend to the Mental Health Division of the State Department of Public Health that all of the clinics should have a physician-director, either full or part-time; and*

(9). *All patients should be referred to the clinic by a physician with sufficient notification and consent of the parents or nearest relative.*

**REFERENCE COMMITTEE RECOMMENDATION**—Concerning item 25 in the report of Council, the Reference Committee points out that this item consisted of the report of the Subcommittee on Mental Health, which included nine numbered sections dealing with specific problems in this area. The Reference Committee approved without change the first and second sections. The third section was approved with the recommendation that the determination of eligibility be made on a statewide basis with some flexibility to be retained at the county level in unusual situations. Sections four and five were approved. Section number six was approved with the additional recommendation that the specific areas mentioned be regional rather than the current congressional districts. Section number seven was approved without change. Section eight was approved with the change that the director of the clinic should be a psychiatrist. Section number nine was approved with the change that consent should also be given by the patient's legal guardian.

**HOUSE OF DELEGATES ACTION**—At this point, Speaker Walker recognized Charles Smith, Columbus, who questioned the use of the term "psychiatric indigency." Dr. Smith then moved for the deletion of section three, in item 25. Speaker Walker called for a second to this motion and there being none, the motion failed.

Dr. Smith then discussed the term "part-pay" in section four of Council item 25. After discussion, Dr. Smith moved to table section four and this motion was seconded by Luther Smith. Speaker Walker called for a vote and the motion to table section 4 was defeated.

Item 25 was then approved as amended by the Reference Committee on motion duly made and seconded.

Thelma Franklin and Mr. Frank Drapalik, our auditor. Due consideration was given to all requests by the chairman of various Boards and Committees concerning their needs for 1965 and conscientious deliberation was given to all and the following budget was proposed, which was reviewed and approved by Council:

All meetings of Executive Committee attended by Chairman of Finance.

	1964 Budget	Actual Jan. 1-Nov. 30, '64	1965 Proposed Budget
<b>INCOME</b>			
I. (a) MAG Dues . . . . .	\$112,829.13	\$113,395.00	\$118,000.00
(b) Int. & AMA . . . . .	4,000.00	4,729.38	5,225.00
(c) GP Service . . . . .	3,250.00	2,979.13	3,250.00
II. ANNUAL SESSION . . . . .	8,750.00	6,925.00	7,350.00
III. JOURNAL . . . . .	35,000.00	22,132.60	32,500.00
Trans. fr. Oper. Cap. . . . .	4,000.00		
IV. CONTINGENT . . . . .	1,434.18	5,434.18	
TOTAL INCOME . . . . .	\$169,263.31	\$155,595.29	\$166,325.00



EXPENSES

I. (a) Fixed Allot. . . . .	\$ 14,625.00	\$ 7,309.97	\$ 14,425.00
(b) Assoc. Office . . . . .	80,565.00	68,216.44	86,635.83
(c) Assoc. Boards . . . . .	20,100.00	14,788.90	20,500.00
(d) Related MAG Act. . . . .	1,400.00	1,523.14	1,400.00
(e) Contingent Fund . . . . .	1,434.18		954.82
" (Tr. Fr. Oper. Cap.) . . . . .	4,000.00	977.17	
II. JOURNAL . . . . .	47,139.13	34,567.26	42,409.35
TOTAL EXPENSES . . . . .	\$169,263.31	\$127,382.88	\$166,325.00

I. (a) FIXED ALLOTMENTS

Payment on Mort. . . . .	\$ 4,000		\$ 4,000.00
Int. on Mort. . . . .	950.00		750.00
MAG Atty. Ret. . . . .	3,600.00	2,700.00	3,600.00
MAG Atty. Expenses . . . . .	300.00	84.97	300.00
Woman's Aux. . . . .	1,875.00	1,875.00	1,875.00
Pension Payments . . . . .	2,400.00	1,650.00	2,400.00
Pres. Honorarium . . . . .	1,000.00	500.00	1,000.00
Annual Audit . . . . .	500.00	500.00	500.00
(A) Sub-Total . . . . .	\$ 14,625.00	\$ 7,309.97	\$ 14,425.00

(b) ASSOCIATION OFFICE

Salaries . . . . .	\$ 51,240.00	\$ 45,500.95	\$ 55,325.00
Ins. & Bonds . . . . .	1,050.00	981.23	1,300.00
Payroll Taxes . . . . .	1,750.00	1,350.40	2,185.83
Travel: Pres. . . . .			1,500.00
Office . . . . .	3,500.00	1,707.72	2,500.00
Del. Sec. to AMA . . . . .			
Annual & Clinic. . . . .	3,000.00	2,275.51	3,000.00
Alt. Del. . . . .	1,200.00	1,027.92	1,300.00
Main. & Repair: . . . . .			
Building . . . . .	750.00	378.68	750.00
Equipment . . . . .	500.00	468.42	500.00
Tel. & Tel . . . . .	4,000.00	3,824.51	4,000.00
Depreciation: . . . . .			
Building . . . . .	2,000.00		2,000.00
Equipment . . . . .	650.00		650.00
Postage . . . . .	3,000.00	3,174.49	3,000.00
Office Supplies . . . . .	2,750.00	2,894.62	2,750.00
Jan. Serv. & Gra. . . . .	1,600.00	1,352.50	2,000.00
Meetings . . . . .	800.00	620.38	800.00
Dues & Sub. . . . .	375.00	372.00	375.00
Heat, Lights, Water . . . . .	2,100.00	2,203.27	2,400.00
Sundry . . . . .	300.00	83.84	300.00
(B) Sub-Total . . . . .	\$ 80,565.00	\$ 68,216.44	\$ 86,635.83

(c) ASSOCIATION BOARDS

1. Annual Session . . . . .	\$ 8,600.00	\$ 7,454.45	\$ 7,210.00
2. Const. & By-Laws . . . . .			
3. Hosp. Acct. . . . .	50.00		50.00
a. Blood Banks . . . . .	150.00	41.00	150.00
b. Hosp. Rel. . . . .	50.00		50.00
4. Govern. Med Serv. . . . .	50.00	59.61	100.00
a. Crippled Child. . . . .			
b. Dis. Med. Care . . . . .	200.00	142.38	200.00
c. Mat. & Inf. Welf. . . . .	300.00	78.86	300.00
d. Pub. Health . . . . .			
e. Rehabilitation . . . . .			
f. Sch. Cld. Hlt. . . . .	1,925.00	399.97	1,500.00
g. Vet. Affairs . . . . .	50.00		
5. Ins. & Econs. . . . .	500.00	87.86	500.00
a. Rel. Val. Study . . . . .	1,000.00	74.13	2,500.00
6. Interprof. Rel. . . . .	125.00	125.00	125.00
7. Legislation . . . . .	2,500.00	2,719.87	2,000.00
a. Nat. Leg. . . . .			

b. State Leg.			
8. Medical Education . . . . .	100.00	94.40	650.00
a. AMAERF			35.00
b. Clks. Labs			
b. Med. Sch. C.			
d. Med. Edu.			
9. Occup. Health . . . . .	300.00	278.20	300.00
a. Ind. Hlt.			
b. Rul. Hlt.			400.00
10. Public Service			
a. Public Ser. . . . .	1,900.00	1,876.83	1,900.00
b. Wky. Hlt. Clm. . . . .	1,600.00	1,144.11	1,630.00
c. Med. & Rel. . . . .	100.00		200.00
11. Special Acct.			
a. Hlt. Care Ag. . . . .	500.00	57.38	400.00
12. Vol. Hlt. Agencies			50.00
a. Cancer . . . . .	50.00		50.00
b. Mental Hlt. . . . .	50.00	154.85	200.00
(C) Assoc. Bds. Total . . . . .	\$ 20,100.00	\$ 14,788.90	\$ 20,500.00

**(d) REL. MAG ACTIVITIES**

AMA Del. Meet. . . . .	\$ 400.00	\$ 382.09	\$ 500.00
Med. Defense . . . . .	300.00	576.16	300.00
Phy. Law Liaison			
Prof. Conduct . . . . .	100.00		
SAMA . . . . .	500.00	500.00	500.00
SMEB . . . . .	100.00	64.89	100.00
(D) Sub-Total . . . . .	\$ 1,400.00	\$ 1,523.14	\$ 1,400.00

**(e) CONTINGENT FUND**

\$ 1,434.18	
Tran. fr. Gen. Fu. . . . .	4,000.00
Retirmt. Tr. Ch. . . . .	\$ 125.00
Presidents Travel . . . . .	852.17
\$ 5,434.18	\$ 977.17

**II. JOURNAL**

Expenses:			
Printing . . . . .	\$ 35,000.00	\$ 24,467.78	\$ 30,000.00
Salaries . . . . .	7,290.00	6,822.90	8,267.50
Bonus . . . . .	722.50		
Insurance . . . . .	160.00	148.59	200.00
Payroll Taxes . . . . .	366.63	269.54	441.85
Engr. & Cuts. . . . .	1,500.00	1,129.13	1,400.00
Sales Tax . . . . .	1,050.00	725.40	900.00
Postage . . . . .	300.00	300.00	300.00
Stationery . . . . .	350.00	315.18	600.00
Clip. Serv. . . . .	200.00	185.60	150.00
Add. & Sup. . . . .	150.00	187.86	100.00
Sundry . . . . .	50.00	15.28	50.00
TOTAL . . . . .	\$ 47,139.13	\$ 34,567.26	\$ 42,409.35

26. Council approved a plan for "trip travel" insurance for all MAG members traveling in behalf of official MAG business and for members of MAG Staff.

27. Council approved workman's compensation, with certain limitations, for members of Staff and also gave its approval to a catastrophic insurance program, with certain limitations, to members of Staff.

28. Council approved a revised "package program" of the existing membership term-life, health and accident, and hospital-nurse catastrophic insurance plan with the Life Insurance Company of Georgia.

29. Council approved a plan whereby GaMPAC dues may be collected on a voluntary basis along with

annual dues for State, County and District Societies. A detailing of this proposal will appear as a supplemental report of the Council.

30. Council approved a recommendation from the Thomas-Brooks County Medical Society that affiliate membership in the Medical Association of Georgia be extended to Albert C. Tuck, D.D.S., an oral surgeon, and Past President of the Georgia Dental Association.

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee recommended approval of items 25 through 30 as printed in the Council report.

**HOUSE OF DELEGATES ACTION**—Adopted that portion of the Council report, including items 26 through 30 as recommended by the Reference Committee on motion duly made and seconded.



**REFERENCE COMMITTEE RECOMMENDATION**—The report of the Finance Committee was approved with commendation.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Finance Committee as recommended by the Reference Committee on motion duly made and seconded.

**Woman's Auxiliary Advisory**

RALPH W. FOWLER, M.D., *Chairman*

This committee is happy to report on it's activities with and in behalf of the Woman's Auxiliary.

Several members of our committee met with Dr. J. G. McDaniel, President, MAG and Mrs. John T. Leslie, President of the Woman's Auxiliary — in their organizational meeting held at the Federal Savings and Loan Building, Decatur, Georgia. We were impressed by the interest, enthusiasm and dispatch with which the officers, representatives and committees from the Auxiliaries from all over Georgia presented their plans for the ensuing year. Their organization was well planned and functioning smoothly.

Previously, our committee had discussed ideas of streamlining and coordinating the many committees of the Woman's Auxiliary. However, in view of this meeting and it's well planned program for such varied and worthy projects, we decided to make no suggestions for any radical changes in their rules and regulations, by-laws or procedure at this time — unless specifically requested by their governing body.

After considerable discussion between ourselves and with the officers of the Woman's Auxiliary, we have come to the conclusion that the annual dues of the members of the Woman's Auxiliary should be collected at the same time as members of the Medical Association — This to be done at the County level. There is much to recommend the idea of collecting these dues at the same time.

- (1) It would be easier to set the dues of the Woman's Auxiliary at a level that would adequately support the many endeavors without the penny pinching they have been obliged to do in the past.
- (2) This method of collecting dues would assure a larger membership for the Woman's Auxiliary which continues to trail that of the MAG by several hundred.
- (3) In all probability this method would allow the entire amount to be tax deductible from Federal and State Income tax returns.

Our committee has stood ready at all times to give counsel and advise to any officers or members of the Woman's Auxiliary. We were pleased to have been consulted on several occasions.

We would exhort the members of our Medical Societies to know their Auxiliaries better. To know them better is to love and appreciate them more.

**REFERENCE COMMITTEE RECOMMENDATION**—This report was approved with emphasis that the collection of dues for the Woman's Auxiliary could be included on the Medical Association of Georgia's members' statement on an individual county basis only where deemed advisable by the county.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Woman's Auxiliary Advisory Committee as amended by the Reference Committee on motion duly made and seconded.

**Constitution and Bylaws**

W. G. ELLIOTT, M.D., *Chairman*

There have been no problems referred to the Board

on Constitution and Bylaws during this year. There has been a printing of the Constitution and Bylaws as revised up to May 1964.

**Supplemental Report of Council No. D.**

**AMENDMENT TO CONSTITUTION AND BY-LAWS TO PERMIT IMMEDIATE PAST PRESIDENT TO SERVE ON COUNCIL FOR THREE YEARS**

ADDISON W. SIMPSON, JR., *Chairman*

At the May 1, 1965, meeting of the MAG Council the following resolution was approved. This matter had been previously referred to the Constitution and ByLaws Board and had been approved by that Board.

"WHEREAS, the ByLaws provide for a retiring President of MAG to serve as a member of Council for only one year, and

"WHEREAS, this short term means loss of valuable knowledge and experience to the Medical Association of Georgia,

"THEREFORE BE IT RESOLVED, that Section 1 of Chapter IV of the ByLaws be amended by inserting at the end of line 2 following "the Immediate Past President, *who shall serve as a full member of Council for a period of three years.*

"BE IT FURTHER RESOLVED, that Section 5 of Chapter VI of the ByLaws be rewritten to read as follows: "Section 5. Immediate Past President. The Immediate Past President shall serve as Immediate Past President for a term of one year following his term of office as President and as such shall serve on Council and its Executive Committee. The following two years he shall continue to serve as a member of Council.

"The foregoing shall be retroactive where it applies."

**REFERENCE COMMITTEE RECOMMENDATION**—The Report of the Constitution and By-Laws Board, together with the additional Supplemental Report of Council No. D, entitled "Amendment to Constitution and By-Laws to Permit Immediate Past President To Serve On Council For Three Years" is approved.

**HOUSE OF DELEGATES ACTION**—Adopted the report of both the Constitution and By-Laws Board and the additional Supplemental Report of Council No. D as recommended by the Reference Committee on motion duly made and seconded.

**Relative Value Study Subcommittee**

H. D. PINSON, M.D., *Chairman*

This year has seen the culmination of our Study on Relative Value. We conducted surveys, made studies of the results and have made our final recommendation to the Council of the Medical Association of Georgia. As instructed by the 1964 meeting of the House of Delegates of the Medical Association of Georgia, the report of this committee has been prepared and forwarded to each county Medical Society and delegate for their study, prior to the 1965 meeting of the House of Delegates.

Our report was approved by the Council of the Medical Association of Georgia. This report, with a cover letter from the Chairman of Council, has been forwarded to each delegate and the President and Secretary of each county Medical Society. This report will be submitted to the House of Delegates for their action during the forthcoming meeting.

(Please see above report of Council)



## Mental Health Subcommittee

W. D. STRIBLING, III, M.D., *Chairman*

In March, 1964, a rotating subcommittee on Mental Health was appointed by the President of the Medical Association of Georgia. This committee consists of one member from each of the ten congressional districts and the Director of the State Division of Mental Health as an ex-officio member. This committee has met on several occasions during the year and has already sent to the Executive Committee of the Medical Association of Georgia a detailed report concerning the endorsement and support of local mental health centers on the basis of seven principles. There is attached to this report a copy of the report which has been approved by the Executive Committee of the Medical Association of Georgia.

The Subcommittee urged support by the Medical Association of Georgia of: (a) It was urged that every County Medical Society in the State and every County Womans' Auxiliary have active Mental Health Committees. (b) That the Medical Association of Georgia go on record as encouraging coverage for mental illness equal to that for any other illness by all non-profit and commercial insurance organizations. During the year one member of our Subcommittee met with the insurance commissioner and work is well underway in this regard. (c) The importance of psychiatric units in general hospital was again emphasized.

Beginning in May, 1963, the Subcommittee has published each month on the Mental Health Page of the *Journal* of the Medical Association of Georgia a series of articles on various subjects concerning mental health. We have elected not to continue these on a monthly basis since this was placing a difficult burden on the *Journal* as well as many members who are preparing these articles. We, at the present time, are placing selected articles on the Mental Health Page and plan to continue this for the indefinite future.

The Subcommittee on Mental Health is grateful for the financial assistance received from the Medical Association of Georgia which enabled the Chairman to attend the AMA Second Annual Congress on Mental Health held in Chicago in November, 1964.

During the year 1964 several meetings were held with the Criteria of Indigency Committee for the Medical Association of Georgia in an attempt to determine some yardstick for eligibility of indigent patients and we feel certain progress was made in this area though much work needs to be done. It should certainly be suggested that the incoming Chairman of the Medical Association of Georgia's Mental Health Committee work vigorously in this area along with the MAG's Committee for Criteria of Indigency.

## Mental Health Subcommittee Report

Approved by MAG Executive Committee

The Medical Association of Georgia Subcommittee on Mental Health after due study and deliberation recommends to the MAG Council for consideration and approval the full endorsement and support of *Local Mental Health Centers* on the basis of the following principles:

(1) That the Medical Association of Georgia goes on record as committing the Association's cooperation in stimulating the staffing of community mental health

programs. It is emphasized that the basic concept of local mental health programs must involve both psychiatric and non-psychiatric physicians in a position of leadership if the community mental health programs are to succeed. At the present time, both psychiatric and non-psychiatric physicians are only partially involved in the treatment of the mentally ill at the local level. Our subcommittee believes that the private practice of medicine must meet this responsibility at the local level in the Community so that the psychiatrically ill patient will not be passed on to the most impersonal type care given by our large State institutions for the mentally ill.

(2) That the Medical Association of Georgia through its component county medical societies exert its influence upon local or community governments to assume some financial responsibility in the establishment of local mental health programs. Local levels of government have up to this time been quite delinquent in supplying funds for the care of the mentally ill at the community level. It is the recommendation of this subcommittee that local governments must begin to appropriate funds for local mental health programs — and along with the financial assistance of the State and federal governments, community health programs can be amply financed. The advantage of the participation of local government is obvious in that the local mental health program can then be "tailored" to suit the needs of the individual community and the program then in fact becomes a local program.

(3) That the Medical Association of Georgia recognize the problem of patient eligibility for care at a local mental health center as may be different from the traditional concept of indigency or medically indigency care. Three factors must be emphasized as the basis for this differentiation: (1) that mentally ill patients frequently lack insurance coverage; (2) that treatment of a long duration may be required; (3) and that the availability of such treatment can be a real problem. Therefore, the subcommittee recommends that a different "yardstick" for eligibility be used and that the term "psychiatric-indigency" be employed to distinguish from other types of health care indigency. The subcommittee believes that the patient eligibility for care in local mental health programs should be set on the basis of an economic yardstick to include the total or partial psychiatrically indigent patient.

(4) That the Medical Association of Georgia recommends the principle of a "patient part-pay" schedule for local mental health programs. The subcommittee recommends that each community mental health program seek to establish as a guideline some type of "pay or part-pay" schedule for psychiatrically indigent patients treated in community mental health centers. The subcommittee believes this concept important in that it would provide for the patient responsibility aspect of medical care and at the same time lend some financial support to maintaining such programs. Such requirements and pay schedules will, by necessity, differ from community to community. For example, such a patient pay schedule is attached to this report. It is based on the number of dependents and has been effective in one community. This schedule is attached as a guideline only and it must be understood that this type of schedule will vary from one community to another.



(5) That the Medical Association of Georgia subscribe to the concept that physicians under certain circumstances will by necessity have to be reimbursed for patient care rendered in a community health program. There are presently available formulas through the State Health Department for pay to physicians; i.e., the Crippled Children's Program, etc., which may be used as guidelines. These formulas might well be adjusted and the method and amount of payment be determined totally as the special needs of the community dictate. It must be emphasized again that such a concept will vary from one community to another depending solely on local factors.

(6) That the Medical Association of Georgia recommends that there be established a Professional Board to include representatives from the local county medical societies, local health officer, Medical Association of Georgia, Georgia Psychiatric Association, and the Department of Public Health. The purpose of this Board is to have authority to "tailor" individual programs to meet the special needs of specific areas where mental health programs are to be established.

(7) That the Medical Association of Georgia recommends the concept that patients be accepted at the regional treatment centers for examination and/or treatment only when referred by a doctor of medicine who may be the regional or local health officer. Exceptions to such plan will be the responsibility of the local Professional Board.

#### **SUMMARY:**

While the maintenance of mental health may or may not be our greatest medical problem today, there is no doubt that this is our greatest unmet medical need at the present time. These seven recommendations are presented — in the hope that the Medical Association of Georgia will assume leadership and in turn seek ways and means to stimulate private practitioners throughout the state to assume their roles in establishing, maintaining, and rendering treatment to the mentally ill at the local community level.

The subcommittee believes that if the private practice of medicine, which certainly includes the private practice of psychiatry — does not as a team assume responsibility in community mental health programs, then surely by default the state and federal governments will pre-empt this responsibility as they see fit with the final result of a less effective level of patient care.

(Please see above report of Council)

#### **Report of the Journal**

EDGAR A. WOODY, JR., M.D., *Editor*

The 1964-65 report of the Journal of the Medical Association of Georgia is submitted herewith.

#### **Personnel**

During the year just past we are pleased to report no changes in personnel. Miss Merrilie Davis has continued as our Managing Editor now for almost three years and is doing a good job.

Our staff of contributing editors from the various branches of medicine have remained active in their assistance to the publication. Their editorial contributions and service in reviewing papers submitted for publication are most helpful and vital in putting together our *Journal*.

#### **Reorganization of State Medical Journal Advertising Bureau**

Since our last Journal report the Editor who serves as a member of the Board of Directors of State Medical Journal Advertising Bureau in Chicago has attended two meetings of the Board called for the purpose of completely reorganizing the sales approach of the Bureau on the national level. We were fortunate to be able to hire the Advertising Director for all AMA publications to head up our sales force in New York. Also hired to assist him in sales is a representative working out of Chicago. We were at the same time able to obtain the part-time services of Dr. Frank Ramsey, Editor of the Indiana State Medical Journal, to serve as president of the organization. The business office of SMJAB was left intact in Chicago since no changes were needed in that area. Although the new organization has functioned for only six months, the impact of the new sales force is already being felt in the form of several new advertising accounts. As an example of the new aggressive posture the Bureau has adopted, very recently Dr. Ramsey along with Dr. Edward Annis and the two new members of the sales force met with the Board of Directors of the Pharmaceutical Manufacturers Association in Washington. Dr. Annie acted as spokesman for our group. The P.M.A. Board received them cordially. It was felt that this contact and presentation will help us in making the ethical drug manufacturers more aware of the value of state medical journals as an effective advertising medium. We are all gratified at these evidences of progress.

#### **Advertising**

As mentioned above, we have already begun to note a modest trend upward in national advertising picture. While no spectacular rise is anticipated, we believe that steady trend in an upward direction is a reasonable expectation. Local advertising has been maintained at about its former level. We are deeply grateful to our local advertisers who have stood fast with us during the period when our national advertising accounts were shrinking. We continue to actively seek local advertising and will follow up immediately on any suggestions for new advertising prospects over the state.

#### **Cost Control**

No new cutbacks in Journal content have been felt necessary or indicated during the year just past. The Journal content has been effectively controlled to balance with our advertising volume. This control is on a month-by-month basis and has proven effective in keeping within our budget.

#### **Journal Questionnaire**

Recently the Journal published a questionnaire to which we received a gratifying number of responses (about 325). A few members even took the time to write letters amplifying on their answers to the questionnaire. While the majority of responses came from those in general practice, all the specialties were represented and showed good geographic distribution over the state. The opinions expressed in the questionnaires are already helping us in our efforts to put out a Journal that our members may be proud of. In addition, our good reader response will be helpful in the promotion of national advertising.



## Credits

An expression of gratitude is due the members of the Publications Committee for their wise counsel and help in dealing with our Journal problems of the past year. We would be remiss if we did not mention the fine quality of our President's Page in the past year.

Mr. Milton Krueger, Mr. Jim Moffett, Mrs. Wooten and Miss Franklin of the Headquarters Office Staff remain stalwart members of the Journal team. Their continued help and cooperation are most appreciated.

**REFERENCE COMMITTEE RECOMMENDATION**—This report was approved with commendation.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Journal of MAG as recommended by the Reference Committee on motion duly made and seconded.

## Woman's Auxiliary to the Medical Association of Georgia

MRS. JOHN T. LESLIE, *President*

During the American Medical Association Convention last summer, the Auxiliary was challenged to be a "good right arm" for their own Medical Association. Let me therefore, picture for you what we in Georgia have been doing and will continue to do in the years to come.

In an effort to make our Auxiliary organization more efficient, an able committee has worked diligently and effectively through the year to up-date our Bylaws. These changes will be presented for approval at the General Meeting in May at Convention.

Since we recognize the great need for community health education, we are encouraging a Health Education Project in each auxiliary. We have stressed the use of AMA Health Education posters and pamphlets throughout the community. The use of films is encouraged both for Auxiliary member's education and for the community. A room is being set aside at convention for Auxiliary leaders to review films and determine how best to use them at the local level. Any suggestions from MAG in this area will be welcomed.

We emphasize the use of the record "Mirror To The Wind" by local radio stations, and the film "The Cry for Help," and other material related to mental health. Our tour of Gracewood State Hospital and School at convention should bring a vivid picture of the mental retardation facts in Georgia. We are proud that one of our Auxiliaries has received a citation from the Kennedy Foundation for their tremendous project on behalf of the mentally retarded.

We are ever mindful of our obligation to encourage students to consider allied medical careers. One Auxiliary has presented a "see and touch" exhibit entitled "Scanning Medicine" to 4000 students during a month's time. What a marvelous way to interest youth in health careers. Other Auxiliaries have provided funds for scholarships in the allied medical fields. One Auxiliary raised over \$2,000.00 for a Nurses Scholarship—asking only that each nurse return to her own county to serve.

We are alert to the needs of AMA-ERF and are aware that seven out of ten medical students are in school today because of loans from AMA-ERF. Through approval of local county societies, "Fun for Funds" money making projects have done just that. One Auxiliary has contributed almost \$700.00 through fund-raising methods and almost all Auxiliaries have a

per member assessment. The total contributed to date is approximately \$3,000.

In May, the W. R. Dancy, MD Student Loan Fund will benefit from a contribution of \$4,000.00 to be given to Mrs. W. R. Dancy.

There has been great woman power in the field of legislation throughout the year. We are better informed about Eldercare, and are endeavoring to inform those with whom we have contact day by day. We have contributed financially and have attended the "Legislative Forum For Women" at the State Capitol.

We thank you for your cooperation and support—both moral and financial. It has been a pleasure to work both *with* you and *for* you. We trust that you will continue to consider us your "good right arm!"

## Recommendations

In order to further serve the purposes of this Auxiliary to the MAG, the following recommendations are submitted:

1. It is recommended—that, when advisable, County Medical Societies be encouraged to include county auxiliary dues with those of the Medical Society. This Team-Membership is urged by AMA. When Team-Membership, or any other plan to produce 100% membership is implemented, the Auxiliary will not require funds from MAG.

2. It is recommended—that County Medical Societies further urge community health projects to be undertaken by their Auxiliaries individually, or in connection with local medical societies. These projects should be carried out in the name of Medical Society and/or the Auxiliary rather than in connection with other organizations.

3. It is recommended—that County Medical Societies be encouraged to call on their Auxiliaries "to work;" for example, the mass polio immunizations and the more recent legislation drives.

4. It is recommended—that District meeting of MAG be changed to Area meetings to make for a more meaningful and well attended meeting.

5. It is recommended—that student loans from the W. R. Dancy, MD, Student Loan Fund and from AMA-ERF be more widely publicized on a state level; and that local county scholarships be more widely publicized on a county level. These scholarships should be increased for students interested in the allied medical fields, when possible.

**REFERENCE COMMITTEE RECOMMENDATION**—This report was approved with the following changes: Item number 1—see the report of the Advisory Committee to the Woman's Auxiliary regarding the collection of dues; item 4—the Reference Committee felt that this should be deleted until after the District changes have been settled by the current House of Delegates.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Woman's Auxiliary to the Medical Association of Georgia as amended by the Reference Committee on motion duly made and seconded.

## Late Report No. X-2

### BOARD OF INTERPROFESSIONAL RELATIONS

WILLIAM COLES, *Chairman*

Representatives of the Medical Association of Georgia were active participants in the Interprofessional Council of Georgia providing liaison with the allied professions of dentistry, pharmacy, and veterinary medicine. This



group provides a forum for discussion of problems and projects common to the several professions at quarterly meetings. This board was otherwise relatively inactive during the past year and encountered no unusual problems.

**REFERENCE COMMITTEE RECOMMENDATION**—This report was approved.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Board of Interprofessional Relations as recommended by the Reference Committee on motion duly made and seconded.

**Supplemental Report of Council No. A**

**VOLUNTARY COLLECTION OF GAMPAC DUES**

ADDISON W. SIMPSON, JR., *Chairman*

The MAG Council, being aware of the great need for a strong political arm of organized medicine, was impressed by an action adopted by the AMA House of Delegates in Miami Beach, last year, which dealt with this subject in an effective manner.

It was recommended at that meeting by a duly constituted reference committee of the AMA House of Delegates that each State consider the matter of collecting AMPAC and State PAC dues on a voluntary basis in the same manner and at the same time as dues are collected for the various echelons of medical organization.

During the course of the discussion of this matter the results achieved in the State of Pennsylvania, which pioneered this concept, were revealed. The results were as follows:

- 78 percent membership in AMPAC and PENPAC in those counties that collected political action committee dues along with their regular State and County Medical Society dues.
- 31 percent membership in those counties that billed separately from State and County Medical Societies, but in the same dues payment envelope.
- 4 percent membership in those counties that collected separate and apart from regular dues statements.

In view of the above results and with the certain knowledge that GaMPAC must be greatly expanded in order to achieve the results expected of it, the Council adopted the following resolution which is submitted for approval to the MAG House of Delegates:

WHEREAS, the House of Delegates of the AMA at its Council Convention in December, 1964, approved the concept of collecting, on a voluntary basis, contributions for AMPAC and State Medical Political Action Committees through the mechanism of the regular dues billing procedure of the State Medical Society, and

WHEREAS, this has resulted in a much higher percentage of participation by physicians in medical political action committees in those States which have adopted this plan,

NOW, THEREFORE, BE IT RESOLVED, that the MAG Council recommends to the House of Delegates that it approve a plan to permit the voluntary collection of AMPAC-GaMPAC dues on the regular annual billing statements provided by MAG to county medical societies, and that the inclusion of this on the dues envelope be clearly marked voluntary and non-deductible.

**REFERENCE COMMITTEE RECOMMENDATION**—The Supplemental Report of Council No. A was approved as reported in Item 29 of MAG Council's report.

**HOUSE OF DELEGATES ACTION**—Adopted the Supplemental Report of Council No. A, "Voluntary Collection of GaMPAC Dues" as recommended by the Reference Committee on motion duly made and seconded.

**Resolution No. 4**

**INSURANCE COVERAGE OF MENTAL ILLNESS**

**FULTON COUNTY MEDICAL SOCIETY**

WHEREAS, a great progress is being made throughout the country in increasing the insurance coverage of mental illness, and

WHEREAS, the insurance coverage of mental illness will permit these disorders to be regarded and dealt with as are physical illnesses, and

WHEREAS, the insurance coverage of mental illness will permit citizens to secure treatment for their emotional difficulties before they become chronic and major problems, and

WHEREAS, the insurance coverage of mental illness will permit citizens to secure psychiatric help in their community, and

WHEREAS, the insurance coverage of mental illness will render unlikely the declaring of the majority of citizens as "psychiatric indigent," and

WHEREAS, insurance coverage of mental illness will help to maintain a more satisfactory balance between the practice of private and public (governmental) medicine,

BE IT RESOLVED THAT the House of Delegates of the Medical Association of Georgia reaffirm its previous recommendation that the coverage of mental illness in Blue Cross and Blue Shield policies be on a regular basis for inpatient and outpatient care in both general and psychiatric hospitals, and

BE IT FURTHER RESOLVED THAT the House of Delegates of the Medical Association of Georgia recommend that health insurance policies use as a guide line the program developed by the American Psychiatric Association, the National Institute of Mental Health and the International Union U.A.W. (In 1966 the program will afford coverage for many thousands of U.A.W. workers in the Atlanta area—see abstract attached.)

BE IT FURTHER RESOLVED THAT the House of Delegates of the Medical Association of Georgia appoint a committee that will direct its efforts to furthering the coverage of Mental Illness by Insurance in the State of Georgia.

**REFERENCE COMMITTEE RECOMMENDATION**—Resolution No. 4 on Insurance Coverage of Mental Illness was approved under Council's report with the following change: The coverage of mental illness not be confined to Blue Cross and Blue Shield policies, but all commercial as well as Blue Plans.

**HOUSE OF DELEGATES ACTION**—Adopted Resolution No. 4 on Insurance Coverage of Mental Illness as recommended by the Reference Committee with the additional recommendation made by the Reference Committee on motion duly made and seconded.

**Supplemental Report of Council No. C**

**AMA COMMENDATION**

ADDISON W. SIMPSON, JR., *Chairman of Council*

At the May 1, 1965, meeting of the MAG Council the following resolution was adopted with instructions



that it be referred to the House of Delegates with a recommendation that it be approved by the House.

WHEREAS, on April 8, 1965, the House of Representatives of the Congress adopted the Administration supported Social Security financed health care for the aged plan (H.R. 6675) over the strong, persistent, and intelligently articulated opposition of the American Medical Association, the Medical Association of Georgia and other State and county medical societies and individual physicians throughout the country, and

WHEREAS, the determined leadership given by the AMA in this legislative campaign accurately and correctly mirrors the true feelings of the vast majority of practicing physicians in Georgia and across the nation, and eloquently testifies to the fact that the AMA is responsive to the wishes of its members,

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia does hereby go on record commending the Officers, Board of Trustees and staff of the American Medical Association for their conduct of this campaign, and

BE IT FURTHER RESOLVED, that the Delegates from MAG to the American Medical Association be requested to introduce a similar resolution commending and expressing confidence in the AMA at the June, 1965 meeting of the AMA House of Delegates.

**REFERENCE COMMITTEE RECOMMENDATION**—Supplemental Report of Council No. C: AMA Commendation, is approved with commendation.

**HOUSE OF DELEGATES ACTION**—Adopted Supplemental Report of Council No. C as recommended by the Reference Committee on motion duly made and seconded.

### **Supplemental Report of Council No. E**

#### **INFORMATIONAL REPORT OF AD HOC COMMITTEE ON CARDIOVASCULAR DISEASE**

ADDISON W. SIMPSON, JR., *Chairman*

The following report was received for information by the MAG Council at its meeting on May 1, 1965. Upon receipt of this report the Council voted to refer this on to the House of Delegates for the information of the House.

It was my privilege to represent the Medical Association of Georgia at the Second National Conference of Cardiovascular Disease in November, 1964. The Conference was held from 22-24 November, 1964, at the Sheraton Park Hotel in Washington, D.C. I was asked by Council to represent MAG; Dr. Willis Hurst represented the Georgia Heart Association and Miss Agnes Newell the Heart Disease Control Division of the State Health Departments. Dr. J. Gordon Barrow was chairman of one of the major divisions of the Conference.

The first day the six hundred delegates were divided into some thirty-five different sections and discussed in detail every parameter of cardiovascular disease, related both to specific illnesses and also to community programming and control. I was placed in this latter division and a report was then made from each section to the three major divisions which were then summarized for the final session of the Conference. I am enclosing with this report and for your records the summary papers of the Conference.

As a result of this, a committee of nine physicians has been activated in order to carry out some of the recommendations of the Conference. Representing the

Medical Association of Georgia are Dr. J. W. Chambers, Dr. Henry Jennings and myself. Three members from the Heart Association and three from the State Health Department comprise the committee.

As an outgrowth of this a Demonstration Stroke Clinic is being organized in Floyd County as a demonstration project under the auspices of the three groups mentioned. It is anticipated that this will grow into other community service areas.

I should mention that this committee is also charged with analyzing the present facilities and services in Georgia and attempting to anticipate areas in which we are not involved. I am happy to say that the work of the State Health Department with the Georgia Heart Association leaves very few of these specific areas which are not already covered. The Committee mentioned above is a self-sustaining one and we shall be happy to make interim reports to Council as our work progresses.

I would like to thank Council and the House of Delegates of the Medical Association of Georgia for the privilege of attending this Conference.

**REFERENCE COMMITTEE RECOMMENDATION**—This report of the Ad Hoc Committee on Cardiovascular Disease was received by the Reference Committee for information.

**HOUSE OF DELEGATES ACTION**—Adopted the Reference Committee Recommendation on the Supplemental Report of Council No. E.

It was moved by Reference Committee No. 2 Chairman Harrison Rogers, Atlanta, and duly seconded, that the report of the Reference Committee be approved as a whole as amended and it was so ordered.

### **Report of Reference Committee No. 3**

**Cecil White, Augusta, Chairman**

*(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)*

Reference Committee No. 3 met in the Embassy Room of the Augusta Town House Motor Inn, Augusta, Georgia, at 2:30 p.m. on May 3, 1965. Members present were: Cecil White, Augusta, Chairman; Wells Riley, Jonesboro, Vice Chairman; Charles Todd, Atlanta, Secretary; Walter Voyles, Waynesboro; A. Richard Gray, Rome; Billy Hardman, Gainesville; F. M. McElhannon, Athens; and Ernest Atkins, Decatur.

#### **AMA Delegates**

J. W. CHAMBERS, M.D., *LaGrange*  
EUSTACE A. ALLEN, M.D., *Atlanta*  
HENRY H. TIFT, M.D., *Macon*

San Francisco is a beautiful city, the food deliciously served in restaurants known the world over for its gormand style. The convention hall was spacious and well organized. The scientific meeting places were scat-



tered and difficult to find. Hotel accommodations were hard to "come by." We arrived on Saturday, the day after the President of the United States and his followers had departed. Our reservations meant nothing. One of our Delegates and an Alternate landed in the Presdenital suite, the last available accommodations in the Headquarters Hotel, for one night while many others were sent hither and yond to other hotels for the night. By noon Sunday all was quiet on the Western Front—and I mean San Francisco. The House of Delegates settled down for business.

The business of the House was varied and voluminous. To mention only a few headliners—human right in which the House of Delegates declared itself unalterably opposed to the denial of membership, privileges and responsibilities in county and state medical association to any duly licensed physician because of race, color, religion, ethnic affiliation or national origin. Tobacco and Health: In adopting a four point reference committee report the House said "The American Medical Association is on record and does recognize a significant relationship between cigarette smoking and the incidence of lung cancer and certain other diseases. The only hope of minimizing the hazards of smoking lies in research." This is the reason for an extensive research program being carried out by the AMA-ERF foundation. Physicians and Hospital Relations: The report of the Council on Medical Service stressed the imperative need for the Medical profession to assume responsibility for the quality, continuity and availability of professional services and for the coordination of these services with the other essential supportive aspect of health care. Cost of Medical Care: The Commission on the cost of medical care presented four volumes to the House of Delegates. The Board of Trustees will study this report and report back to the House at the 1964 Clinical Meeting. Other subjects discussed were continuing medical education; the federal subsidization of prepayment plans and health insurance; the creation of the section on allergy approved; inquiries in the problem of unwed mothers and illegitimacy; called for legislative guidance on the physical abuse of children; the establishing of a wire communication system between the A. M. A. headquarters and the state medical societies.

The retiring president in his address to The House of Delegates recommended a yearly gradual increase of dues up to \$100.00 in 1967. He followed his recommendation to the reference committee, the committee passed it on to the House. During the House discussion there arose one of the greatest hassels in parliamentary procedures I have ever witnessed in my years as a Delegate. Finally one of our Delegates spoke opposing the entire procedure as premature and that such matters should be evaluated before a change in dues is made so the matter was referred to the Board of Trustees.

The AMA Distinguished Service Award for 1964 went to Dr. Irvine H. Page for his work on Cardiovascular and Renal diseases. The Joseph Goldberger award in Clinical Nutrition was given to Dr. William J. Darby of Vanderbilt University School of Medicine.

On Tuesday night Dr. Norman A. Welch was installed as president. In his address "Unity in Medicine" he stressed the fact that "medicine must be united if it is to serve the public in the future to the highest degree that it has in the past."

Dr. Donavon F. Ward, Vice-President of the A.M.A. was elected President-elect. This is the first time in the 113 years that a Vice-president has been elected to the office of President-elect following his year as Vice-President.

There was a total registration of 49,437 with a total of 14,229 physicians. The majority of those who attended considered the Scientific Exhibits as one of the greatest contributions to graduate education ever presented at any A. M. A. convention. Soon the inconvenience that occurred on opening day were forgotten and the House selected San Francisco for the 1968 session.

For our Clinical Convention we journeyed from the beautiful city of San Francisco to the play grounds of Miami Beach, Florida. Here we found plenty of hotels, sand beach and adequate convention hall but due to the long narrow beach communication was difficult and scientific meeting were hard to find. The weather was not the liking of the Chamber of Commerce of Miami Beach but a wonderful meeting took place and the House of Delegates had much work to do.

There was a sad note to the meeting due to the death of Dr. Norman A. Welch, who died in the line of duty for the A. M. A. A great man, a dedicated physician and a true member of the A. M. A. A tribute and due respect was paid to his memory.

Since Dr. Welch did not serve six months of his time Dr. Norman Ward was sworn in, in Chicago and a President-elect had to be selected at this Clinical Meeting. Dr. James Appel of Lancaster, Pa. was elected, Dr. Joseph Copeland from Texas was elected to the Board of Trustees to fill the vacancy left by Dr. Appel.

Health care for the aged was the outstanding problem at this session. The splendid address of President Ward strongly endorsing the A. M. A. stand was made at the opening meeting on Monday. Reaffirming our stand against the King-Anderson type of legislation and asking all physicians to fight such actions, Dr. Ward said, "If we have been right in the past, and that is our unshakeable belief, then we are right today and we will be right tomorrow." If you have not read his address then do so and get out and fight for your rights and the rights of your patients.

A new teletype communication system between A. M. A. Headquarters and state societies has been installed.

To carry out the appeal of Dr. Ward the House gave unequivocal approval of the Board of Trustee's suggestion that an expanded educational program for the public be conducted during the next few months. The House refused to act on three resolutions which would have altered the A. M. A. position on health care legislation.

With modification, suggested by the Board of Trustees, the House approved 33 recommendations from the Commission on the Cost of Medical Care. The House learned that a large number of the studies recommended by the Commission are already under way.

The House agreed that there should not be an increase in A. M. A. dues at this time.

The A.M.A. Research Foundation reported to the House that one out of every six medical students, interns and residents in the U. S. are now receiving financial assistance from the Foundation's loan fund.

Many other important measures were discussed and passed on.



We are aware and pleased at the work the Auxiliary of the A. M. A. and the many States for their deeds and cooperation.

We want all the MAG members to know about the Southeastern Hospitality room. It is open to you and for your benefit. When at the AMA convention come by and visit us.

The MAG Delegates attended all the meetings and took an active part in the deliberations. The Alternate Delegates were also present together with officers of the Association. We could not do the work without their help. With so many reference committees and other activities we can always use help from our Association.

I wish to thank the MAG Delegates for cocktail party given for me in the hospitality room as a final tribute. Many friends from the House came by to say goodbye.

This being my last will and testament as a Delegate from you to the AMA I want to thank you from the bottom of my heart for your confidence in me and I pray that I served you well. I leave with regrets but I know that your Association's business is in good hands. From them you hear of great achievements in the near future. Back them and let them know you are behind them all the way.

**REFERENCE COMMITTEE RECOMMENDATION —** Report of Drs. J. W. Chambers, Eustace A. Allen, and Henry H. Tift. This report was read by Dr. Todd. Dr. J. W. Chambers was in attendance and made several comments concerning the report. He felt that more members of the Medical Association of Georgia should attend the AMA convention since there was a considerable amount of work present, and that any members attending could help with the work at hand. The committee would especially like to commend Dr. Eustace A. Allen for his fourteen years of service as a delegate to the AMA from the MAG. In addition, we would like to note that he was Vice President of the AMA for the term 1952-1953. The committee voted to approve with commendation this report.

**HOUSE OF DELEGATES ACTION—**Adopted the report of the AMA Delegates as recommended by the Reference Committee with the additional recommendations made by the Reference Committee on motion duly made and seconded.

Alternate Delegate

PRESTON D. ELLINGTON, M.D., *Augusta*

I sincerely appreciate having had the opportunity to represent the members of the Medical Association of Georgia as Alternate Delegate to the American Medical Association in 1964.

I attended the annual session held in San Francisco, California in June 1964 and the clinical session held in Miami Beach, Florida in December 1964. At these meetings I attended all sessions of the House of Delegates, the breakfast meetings of the Georgia delegation for discussion and review of all matters before the House, and all Reference Committee assignments of the House of Delegates.

While I can only speak for myself, I don't mind saying that I was profoundly impressed with the magnitude of the AMA's activities during the past year. It is difficult to understand how anyone could be critical of the AMA if they only knew the scope of its interests and the details of its accomplishments. During the past year it has been gratifying to me that the Association, although subjected to one of the strongest political attacks in its entire history, has not forgotten or neglected its promotion of the science and art of medicine and the betterment of the public health.

The Delegates, my fellow Alternate-delegates, and

the officers and staff of the Medical Association of Georgia are to be especially commended for their work in the Georgia delegation at these meetings.

Again, may I say that it has been a privilege and an honor to serve as Alternate-Delegate to the American Medical Association from Georgia.

**REFERENCE COMMITTEE RECOMMENDATION—**The committee approved with commendation the report of Dr. Preston D. Ellington, AMA Alternate Delegate.

**HOUSE OF DELEGATES ACTION—**Adopted the report of the AMA Alternate Delegates as recommended by the Reference Committee on motion duly made and seconded.

Third District Councilor

FRANK A. WILSON, M.D., *Leslie*

The Third District has seven organized Societies. Following redistricting, one of these societies was completely removed, and three of the others are split. There are no new societies in the counties added to the district. These changes will constitute major problems in district organization.

The District Society had its Fall meeting in Americus and the Spring meeting was a Lederle Symposium on cardiovascular diseases in Columbus, Georgia, on April 8, 1965.

As Councilor for the Third District, I have attended all of the regular and call meetings of the Council.

Counties and Secretaries	Members		Members	
	December 31, 1964		December 31, 1963	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Ben Hill-Irwin				
Ralph Roberts				
Fitzgerald . . . .	10	9	10	9
Flint				
C. C. Goss				
Ashburn . . . . .	15	13	14	13
Peach Belt				
Harry E. Sims				
Fort Valley . . . .	35	30	32	28
Ocmulgee				
Ray L. Johnson				
Eastman . . . . .	15	10	16	11
Randolph-Terrell				
Carl E. Sills				
Cuthbert . . . . .	13	11	13	11
Sumter				
H. L. Simpson				
Americus . . . . .	21	17	21	16
Taylor				
E. C. Whatley				
Reynolds . . . . .	3	2	3	2
	112	92	109	90

**REFERENCE COMMITTEE RECOMMENDATION—**Dr. Wilson was present for this report and discussed the report with the committee. He felt that redistricting will bring many problems to those counties in which there will be division involving county medical societies. This report was approved with commendation by the committee.

**HOUSE OF DELEGATES ACTION—**Adopted the report of the Third District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Muscogee County Councilor

LUTHER H. WOLFF, M.D., *Columbus*

The Muscogee County Medical Society has again been quite active during the past year. In view of the



eminence of the showdown on the King-Anderson legislation, particular emphasis was placed on political matters.

The County Medical Society Officers met at the suggestion of the Councilor at a luncheon meeting with the entire Muscogee County Delegation to the General Assembly prior to the last session of the Assembly. Particular stress was placed on the desirability of having Kerr-Mills funds available for implementation of the MAA phase of this legislation and it is believed that our arguments relating to this matter were well received by our legislators.

A Speakers Bureau was established by the Muscogee County Society during the past year to discuss the medicare problem before any interested public group. Speakers from this panel were requested by numerous civic clubs, womens clubs, professional groups, and others. It is believed that this activity was well worth while in forming public opinion in the Third District. Two of the panelist participated in a half-hour television question and answer program on the topic Medicare vs. Eldercare.

The Muscogee County Medical Society sent a representative to the Governor and to the immediate past governor of Georgia to urge implementation of the Kerr-Mills program.

The Councilor has attended all meetings of the Muscogee County Medical Society and reports regularly on the activities of the Council, especially on legislative and political activities. The Councilor has attended all meetings of Council except one during the past year and cooperated with the Officers of the Medical Association of Georgia in every way possible during the past year.

The Councilor feels it is an honor and privilege to serve on the Council of the Medical Association of Georgia as representative of the Muscogee County Society.

As a footnote, the Councilor wishes to congratulate and thank the Officers and members of the Muscogee County Medical Society, the Officers of the Medical Association of Georgia and his fellow Councilors for the cooperation and attention to duty that these various individuals have exhibited during the past year.

Counties and Secretaries	Members December 31, 1964		Members December 31, 1963	
	MAG Dues Paying Only	AMA	MAG Dues Paying Only	AMA
Muscogee				
Edmund M. Molnar				
Columbus . . . .	114	100	108	98

REFERENCE COMMITTEE RECOMMENDATION—The report of the Muscogee County Medical Society Councilor was approved with commendation by the committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Muscogee County Medical Society Councilor as recommended by the Reference Committee on motion duly made and seconded.

Fourth District Councilor

VIRGIL B. WILLIAMS, M.D., *Griffin*

The Councilor of the Fourth District has attended all regular and called meetings of the Council during the past year.

Formal and informal consultations have been held with members of the Association residing in the Fourth District. During the year the Councilor has remained in contact with activities of all societies in his District.

Problems concerning organization and ethics assigned by Council have been completed.

The Councilor has been ready at all times to advise on problems pertaining to the office.

Counties and Secretaries	Members December 31, 1964		Members December 31, 1963	
	MAG Dues Paying Only	AMA	MAG Dues Paying Only	AMA
Clayton-Fayette				
Wells Riley				
Jonesboro . . . .	5	5	5	5
Coweta				
W. E. Barron				
Newnan . . . . .	21	14	22	16
Lamar				
S. B. Traylor				
Barnesville . . . .	4	4	3	3
Meriwether-Harris				
Emmett Collins				
Manchester . . . .	16	8	14	8
Newton-Rockdale				
E. J. Callaway				
Covington . . . . .	11	8	11	8
Spalding				
Arthur Krepps				
Griffin . . . . .	44	37	44	36
Troup				
Joseph F. Kraft				
LaGrange . . . . .	42	33	41	34
Upson				
L. L. Allen				
Thomaston . . . . .	16	13	15	12
	159	122	155	122

REFERENCE COMMITTEE RECOMMENDATION—The report of the Fourth District Councilor was approved with commendation by the Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Fourth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Fourth District Vice Councilor

CHARLES T. COWART, M.D., *LaGrange*

This Vice-Councilor has attended all meetings of Council except one. I am now the President of the Fourth District Medical Society.

Most of my activities during the past two years have been concentrated in the Georgia Hospital-Medical Council. This Council has been very active in inspecting, educating, and attempting to upgrade the small hospitals in Georgia. The inspection and accreditation program for nursing homes in Georgia is finally underway. The Standard's Manual and check lists have been published and training sessions held for nursing home administrators and inspectors in Macon and Atlanta.

This organization has gotten along quite well until now utilizing the volunteer secretarial work of the Executive Secretaries of the Medical Association of Georgia and the Georgia Hospital Association. With the great increase in work load to be added by the Nursing Homes inspection program, this Council has reached a cross-road. We must: (1.) Get along as well as we can with such spare time as these two able gentlemen can give us or (2.) Employ a secretary to devote full time to these two programs.

A great deal of the increase in work is due to the fact that the inspection and accreditation activity has been expanded to include hospitals of greater than 25 beds who have applied for approval for participation



in the OAA program. We have just been designated as inspecting agency for nursing homes who wish to participate in the OAA program. We will shortly have 150 or more inspection requests from nursing homes.

It is recommended that the Medical Association of Georgia and/or the Department of Family and Childrens Services give early attention to this problem of financing and hiring a secretary. This employee might well have other duties with various boards and committees of the Association. Or, he or she might be employed on a part-time basis to serve only the Georgia Hospital-Medical Council.

**REFERENCE COMMITTEE RECOMMENDATION**—Dr. Cowart was in attendance and discussed the report. Dr. Cowart asked that we delete from his report phrases in the first sentence of the last paragraph. This sentence should read with its correction as follows: "It is recommended that the Medical Association of Georgia give early attention to this problem of financing and hiring a secretary." Dr. Cowart stated that the work load of the Georgia Hospital-Medical Council was increasing considerably particularly due to the program of inspecting nursing homes and hospitals and also the inspection of many hospitals over the 25 bed limit which have not been approved by the Joint Committee on Accreditation. It was his firm belief that a secretary should be hired for full or part-time work with the Georgia Hospital-Medical Council. The committee discussed this problem and voted for approval with the additional recommendation that it be referred to Council for investigation and action.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Fourth District Vice Councilor as amended by the Reference Committee with the additional recommendation made by the Reference Committee on motion duly made and seconded.

### Fifth District Councilor

FLOYD R. SANDERS, JR., M.D., *Decatur*

During the past year the Fifth District Medical Society has continued the rapid rate of growth noted in previous years. Its members have continued to make worthy contributions to all fields of medical science. Several members continue to make national medical news.

The activities and contributions of Fulton County Medical Society toward the welfare of this community have been outstanding, and a detailed report will be given by its own Councilor and Vice Councilor.

The DeKalb County Medical Society has experienced another "medically" prosperous year. Members have been active in all civic as well as medical affairs of the community. The entire society put maximum effort into the S.O.S. campaign in the district to help make it a most successful "operation." A large number of the society's members took part in the first Medical Public Forum to be held in this county under the sponsorship of the society and another civic minded institution. Four separate forums were held with each one covering a medical subject of particular interest to the public. These were very successful and it is anticipated that there will be more to come.

A major portion of the care of the sick and injured continues to center around DeKalb General Hospital, Emory University Hospital, and Egleston Hospital for Children. Emory and Egleston have continued to expand their clinical and teaching programs. DeKalb General is making plans to add to the physical plant in such proportions that will raise the bed capacity to 400 (double its present size).

The Fifth District Annual Meeting was held on Nov. 5, 1964, and a most interesting and informative presentation on "Submarine Medicine" was given by Captain Charles L. Waite, MC., USN. The meeting was

presided over by the out-going President Dr. Robert I. Gibbs. Dr. Carl C. Jones, Jr. was elected President; Dr. John Trotter, Vice President; Dr. Paul Teplis, Secretary-Treasurer. The present councilor was re-elected and Dr. M. F. Simmons was elected Vice Councilor.

Counties and Secretaries	Members December 31, 1964		Members December 31, 1963	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
DeKalb				
Catherine E. Foster				
Decatur . . . . .	153	138	139	120

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee voted to approve the report of the Fifth District Councilor with commendation.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Fifth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

### Fulton County Councilor

CHARLES S. JONES, M.D., *Atlanta*

The Council of the Medical Association of Georgia has had a busy year. Of particular interest to members in Fulton County is the "reapportionmen." Under this change Fulton County will have two Councilors this year. By next year, because of increasing membership we will have three Councilors representing Fulton County. With the rapidly changing countenance of medical practice in the United States the importance of the medico-political field acquires increasing significance. Although it is quite difficult to predict at this time, or even to imagine, it is fair to assume that our Federal Government will assume rapidly increasing economic interests in health care in this country. Those participating in the existing medico-political structure in our state will have grave responsibilities in assisting federal bureaucracies to formulate policy for the application of centralized medical policy to our local communities. We must be both wise and cautious in the selection of our representatives for this difficult task.

Doctors are often unaware of medical events outside of their particular field of interest. For the past several years we have all been aware of a large socio-medical ground swell which will shortly reach its crest and come roaring in on the beach. To deny that there is a complete absence of need for some change would be to ignore the facts. However, most doctors who are concerned with the health of our communities sincerely believe that the changes and new programs contemplated in Washington go far beyond any need and will result in deterioration rather than improvement of health care. The American Medical Association has made an ardent effort to tell the "doctor's story." In this endeavor there has been something less than complete success. At this point there is little value in criticizing the failures at hand. We might better occupy our time in picking up the pieces and repairing the structure as best we can.

"Medicare, Eldercare, Federal Care" or King Anderson — whatever the title of the national bill for elderly health care is not really important in the long term thinking of this new philosophy. President Johnson recently emphasized that this great nation has three basic problems to which the Federal Government should address itself: Poverty, Ignorance and Disease. At the risk of being pessimistic it is my considered opinion



that whatever medical legislation passes in the coming year it will be only the start of a more extensive program which will be introduced in stages over the next decade. Our continued opposition to these changes will not altar the basic course of events. What then should we do to favorably influence the long-term course of health care as is has to do with education, research, and patient care?

Doctors must make every effort to better understand the socio-medical revolution at hand. In spite of the fact that we may not agree with the changes; we must work with these programs. We must have representation both locally and in Washington. This representation should devote itself to understanding and negotiating with the agencies involved in the implementation of the new laws as they come into being. To do this would not be to surrender, but rather to recognize the facts of life and attempt to create the most favorable environment possible to good medical care.

As one who has been outspoken in opposition to the type medical legislation which seems certain to pass in Congress, this present writing may sound like complete capitulation. Maybe it is. However, I believe it is the most practical way in which the medical profession can do its best job in rendering care to the sick. After all this is the primary purpose of our existence.

As the Federal Government becomes a major partner in medical care the medical profession must exert every influence in moulding the direction for medical education and practice in the United States. May the Lord look favorably on our efforts.

The Council of the Medical Association of Georgia is aware of the possible changes in the course of medicine. They will do their best to favorably influence this course of affairs. Some things will be done because the law requires it. Others will be done according to the best judgment of the group. But all things will be done in an effort to see that the best possible medical care can be rendered.

Counties and Secretaries	Members		Members	
	December 31, 1964		December 31, 1963	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Fulton				
William W. Moore, Jr.				
Atlanta . . . .	1,039	852	1,014	788

**REFERENCE COMMITTEE RECOMMENDATION**—The report of the Fulton County Medical Society Councilor produced considerable discussion in the Committee due to the fact that it involved the problems of "Medicare," "Eldercare," and "Federalcare" programs. Dr. Jones has recommended that doctors must make every effort to better understand the socio-medical revolution at hand. In spite of the fact that we may not agree with the changes we must work with this program. We must have representation both locally and in Washington. This representation should devote itself to understand and negotiate with the agencies involved. It was the belief of the committee that the representatives referred to above should be appointed by the Medical Association of Georgia. It was also the feeling of the committee that a representative or representatives should be sent to Washington to inform the Georgia Senators and Representatives of our desire for MAG representation in negotiating with the agencies involved in the implementation of present and future laws concerning health. This report was approved with commendation by the committee with the additional recommendation that it be transmitted through Council to the American Medical Association.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Fulton County Medical Society Councilor as recommended by the Reference Committee with the additional recommendation made by the Reference Committee on motion duly made and seconded.

**Fulton County Vice Councilor**

LINTON H. BISHOP, JR., M.D., *Atlanta*

The Vice Councilor has attended most of the Coun-

cil meetings, and has worked with the Councilor in presenting the problems of Fulton County to the State Association. He has also worked as a liaison agent between Council and the Fulton County Medical Society.

**REFERENCE COMMITTEE RECOMMENDATION** — The Reference Committee voted approval of the Fulton County Medical Society Vice Councilor report.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Fulton County Medical Society Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

**Public Service Board**

LINTON H. BISHOP, JR., M.D., *Chairman*

In the past year the Public Service Board has been active in several fields and has endeavored to carry out several projects and to continue others already started.

During the year the Public Service Board cooperated with the AMA, and was instrumental in placing information in several of the papers throughout the state regarding Health Care for the Aged before the last election. We have continued to work with the news media in trying to better our relations with them. We have continued to participate in the Good Health for Georgia campaign in cooperation with the Georgia Dental Association, the Georgia Pharmaceutical Association and the Georgia Hospital Association. This was done under the auspices of the Georgia Association of Broadcasters.

The Public Service Board co-sponsored a conference of the medical leaders of Georgia with the President of the AMA. During this conference a real effort was made to familiarize our physicians with the problems at hand and we were inspired by our President Donovan Ward's address on "The Will to Win." This conference was also a workshop for the county medical societies in planning the county medical societies activities. He had good participation at this conference and the speakers were well received.

The Public Service Board also helped with the Regional Conference on Medicine and Religion held in Atlanta by the Rev. Dr. Paul McCleave.

The Public Service Board agrees with the proposed action by the Weekly Health Column Subcommittee and we wish to thank the Chairman of that committee and all the members, who during the past several years have worked so hard to make "Doc MAG Says" a success.

As usual, the MAG Office Staff has done an outstanding job in helping with these activities.

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee approved the report of the Public Service Board with commendation.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Public Service Board as recommended by the Reference Committee on motion duly made and seconded.

**Medicine and Religion Subcommittee**

W. HARRISON REEVES, M.D., *Chairman*

In the first instance I would call attention to the fact that we have had meetings since the last report in December and again anticipating a meeting on April 20. The December meeting was a successful one bringing together some of the original members of the group and introducing new State level members from various



areas who had not been present previously. The meeting was a successful one and our guest was Chaplain Charles Gerkin of the Grady Memorial Hospital Chaplain Staff who is also the Executive Director of the Georgia Association of Pastoral Care. Chaplain Gerkin discussed our joint interests at some length. Then, Dr. Charles Fulghum who is the Chairman of the Fulton County Committee and who is an active psychiatrist interested in the area of psychology, religion and healing discussed some of our aims from a professional point of view and made suggestions to us. At this meeting seven different committee members indicated active efforts in their areas. Since that time I have heard of activity from Dr. Pittard in Toccoa, Georgia and from Dr. Meadows in Cobb County where a great deal of activity is in progress. Fulton County has had its program inaugurated.

Our next semi-annual meeting was held on April 20 at Emory University and was a supper meeting. The excitement of this occasion hinged around the visit of Dr. Paul Tournier, worldwide known physician who has written extensively in the area of psychology, religion and healing. He was the guest of the Georgia Association of Pastoral Care, the Mental Health Unit for the Medical Association of Georgia and our meeting with him was a matter of an afternoon, supper and evening lecture on Monday, April 20.

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee voted approval with commendation on the report of the Medicine and Religion Subcommittee.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Medicine and Religion Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

### Weekly Health Column Subcommittee

J. RHODES HAVERTY, M.D., *Chairman*

The Weekly Health Column Subcommittee met regularly every three months during 1964 and submitted to the newspapers during the year a total of fifty-two articles for publication.

At the request of the committee an investigation was conducted to determine the number of newspapers that were printing the articles each week. The results of the survey showed that of the 275 papers that received the column each week, 97 published the article in a three months clipping service check. Of these 97 the articles were not published each week of the 17 weeks involved but on an average of six or seven times during the period. A letter was then mailed to the editors asking their opinion regarding the continuance of the publication of the column. Out of 275 papers only 68 replied with many editors stating that the articles were advertising and that the Association should pay for the publication. The committee members were then polled with the result that the majority voted to discontinue publication of the articles.

Your committee chairman then discussed the matter with the President of MAG who agreed with the committee's decision and the matter was presented to the MAG Council at the December 1964 meeting. Council approved the disbandment of the committee due to the decline in publication of the articles. A letter was then mailed to the editors of the Georgia newspapers as follows:

"Several years ago a group of doctors from the Medical Association of Georgia decided that, as a

public service, they would try to write authoritative articles explaining various diseases and medical conditions to the people of Georgia. They would distribute these at no cost to the newspapers of our state, for them to use as they best saw fit. The articles apparently served a real need, and were received with enthusiasm by many editors and readers. There has been one article sent out each week for 6 years totaling over 300 articles, that more than 20 doctors have given of their time and knowledge to create.

Recently, we have noticed a lessening of response, and wondering if our readers have become saturated with medical information, sent out cards to the editors asking for opinions as to whether we should continue our efforts or not. We found that 97 papers of about 300 were using our articles, but on an irregular basis. Much to our surprise, also, we received several comments from editors stating that they considered our articles advertising, and that they felt they should be paid for publishing them.

Consequently, because of this lessening of interest, and because of this misinterpretation of what we felt was a public service, we have decided to discontinue the articles as of the end of December, 1964. If, in the future, it seems desirable to begin again furnishing this type of information we shall be most happy to do so, for our aim, like yours, is for a healthier, better informed Georgia.

Sincerely,  
J. Rhodes Haverty, M.D."

It is with real regret that the committee was disbanded but in the time from 1958 through 1964 it is felt that some good has been done for the people of Georgia. I wish to thank all of the members who served on the committee, as well as the MAG Staff, for their generous contributions toward our aim, as stated in the letter, "for a healthier, better informed Georgia."

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee noted with regret the disbandment of the Weekly Health Column Subcommittee due to a decreasing response on the part of many of the editors of newspapers and the readers. The committee expressed appreciation to Dr. Haverty for his work with this committee and expressed deep regret to note that several editors of papers in Georgia felt that this column was actually a form of advertisement and that the Medical Association of Georgia should pay for publishing it. The committee voted the approval of this report with commendation.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Weekly Health Column Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

It was moved by Reference Committee No. 3 Chairman Cecil White, Augusta, and duly seconded, that the report of the Reference Committee be approved as a whole, and it was so ordered.

### Report of Reference Committee No. 4

J. T. Christmas, Vienna, Chairman

*(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)*

Reference Committee No. 4 met in the Embassy Room of the Augusta Town House Motor Inn,



Augusta, Georgia, at 2:30 p.m., on May 3, 1965. Members present were: J. T. Christmas, Vienna, Chairman; Lamar Peacock, Atlanta, Vice Chairman; Charles R. Smith, Columbus, Secretary; S. H. Storey, Valdosta; F. M. Lindsey, Warner Robins; F. R. Miller, Thomasville; and J. Frank Harris, Atlanta.

First District Councilor

CHARLES E. BOHLER, M.D., Brooklet

As First District Councilor, I have attended all scheduled and called meetings of the Council.

I have attempted to acquaint the members of MAG throughout the First District with the plans and ideas of the Medical Association of Georgia and the AMA.

I hope to be able to meet with more of the societies in the First District during 1965.

The meeting of the First District Medical Society was held in Statesboro in April.

Counties and Secretaries	Members		Members	
	December 31, 1964		December 31, 1963	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Bulloch-Candler-Evans				
C.E.Bohler				
Brooklet . . . . .	17	16	16	14
Burke				
Charles G. Green				
Waynesboro . . . .	8	6	8	6
Emanuel				
R. G. Brown				
Swainsboro . . . .	7	6	7	6
Jenkins				
A. P. Mulkey				
Millen . . . . .	3	3	3	2
Screven				
W. G. Simmons				
Sylvania . . . . .	5	5	5	6
Southeast Georgia				
L. C. McRae				
Glenwood . . . . .	29	22	26	20
Tri-Liberty-Long-McIntosh				
O. D. Middleton				
Ludowici . . . . .	5	3	3	2
	74	61	68	56

REFERENCE COMMITTEE RECOMMENDATION—The Committee received the report of the First District Councilor with approval.

HOUSE OF DELEGATES ACTION—Adopted the report of the First District Councilor as recommended by the Reference Committee on motion duly made and seconded.

Georgia Medical Society Councilor

WALTER BROWN, M.D., Savannah

The Georgia Medical Society has had another successful year under the able guidance of Dr. A. F. Williams. Present membership numbers one hundred fifty eight.

During the year I attended all regular and special meetings of the Council. Also a special called meeting of the AMA in Chicago in December 1964 at which time decisions were made as to action to be taken in reference to medical legislation.

During the year the Georgia Medical Society deeded its building and property to the Warren A. Candler Hospital. The hospital agrees to furnish meeting quar-

ters for the Society in the building. The hospital is also furnishing food service for the monthly meetings.

Another new step forward was the employment of a new secretary, Mrs. Lee Giffen. She has already contributed a great deal to the business operation of the Society, relieving the president of much detail.

The new officers; Dr. Robert Gottschalk, President; Dr. William Osborne, Vice President; Dr. Jeff Holloman, Secretary; Dr. J. J. Doolan, Treasurer. Also we are proud to have Dr. Kirk Train as First Vice President of the Medical Association of Georgia and Dr. David Robinson as President of the First District Medical Society.

We have been fortunate in having outstanding speakers for the scientific programs and excellent social hours preceding the meetings. These two factors have contributed to a very marked increase in our attendance. We welcome increased attendance also from the Medical Staffs at Ft. Stewart, Hunter Field and The U. S. Public Health Service Hospitals and urge these men to attend as frequently as they are able to do so.

Counties and Secretaries	Members		Members	
	December 31, 1964		December 31, 1963	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Georgia Medical Society				
J. J. Holloman				
Savannah . . . . .	158	142	155	141

REFERENCE COMMITTEE RECOMMENDATION—The Committee received the report of the Georgia Medical Society Councilor with approval.

HOUSE OF DELEGATES ACTION—Adopted the report of the Georgia Medical Society Councilor as recommended by the Reference Committee on motion duly made and seconded.

Sixth District Councilor

WILLIAM RAWLINGS, M.D., Sandersville

Since the 1964 Annual Session of the Medical Association of Georgia, this Councilor has attended all Council meetings except one, at which time patient care necessitated missing the Albany meeting of the Council. All other important meetings concerning State and national legislation have been attended and information disseminated to county societies and lay public whenever possible.

I believe the lay public is better and more fully informed as to medical programs than ever before. The general public has a fair knowledge and is conscious of the danger of such legislation as the King-Anderson type. No one with whom I have discussed this matter seems to be in favor of such a program, nevertheless many of our State and national leaders seem determined to push, centralize, and regiment. It is also regrettable that many of our own profession take the fatalistic and disinterested attitude.

The Sixth District will be split completely at the 1965 Annual Session if the House of Delegates votes to conform medical district lines to Congressional District lines. The majority of this district will be in the Tenth and will continue to cooperate fully with the leaders of our new district.

Attached is a list of counties and membership. Again it should be noted that the total AMA membership gradually increases showing that the practicing physician in this rural area is more and more concious of the work, good leadership, and value of the American Medical Association.

Counties and Secretaries	Members December 31, 1964		Members December 31, 1963	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Baldwin				
A. C. Martinez				
Milledgeville . . . .	29	24	31	25
Jasper				
E. M. Lancaster				
Shady Dale . . . .	4	4	3	3
Jefferson				
Walter J. Revell				
Louisville . . . .	5	4	7	5
Laurens				
Ridley M. Glover				
Dublin . . . .	34	15	30	15
Washington				
Dean L. Holmes				
Sandersville . . . .	13	6	12	3
	85	53	83	51

REFERENCE COMMITTEE RECOMMENDATION—The Committee received the report of the Sixth District Councilor with approval.

HOUSE OF DELEGATES ACTION—Adopted the report of the Sixth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

### Seventh District Councilor

RALPH N. JOHNSON, M.D., *Rome*

The Seventh District has had another year of medical activity. The semi-annual meetings have been interesting and well attended.

There has been an intensive effort in combating the King-Anderson Bill in favor of the Eldercare Bill and we feel that our representative in Congress will go with us all the way. However, there will probably be a vote on this before our annual meeting in May and we will learn whether our efforts were in vain or not.

We are looking forward to another pleasant year.

Counties and Secretaries	Members December 31, 1964		Members December 31, 1963	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Bartow				
Virginia Hamilton				
Cartersville . . . .	8	6	8	7
Carroll-Douglas-Haralson				
Frank Green				
Villa Rica . . . .	33	29	36	32
Chattooga				
Herman E. Spivey				
Summerville . . . .	7	7	7	7
Cobb				
W. B. Matthews				
Marietta . . . .	102	95	88	83
Floyd				
Richard W. Leigh				
Rome . . . .	69	61	68	59
Gordon				
L. R. Lang				
Calhoun . . . .	9	7	9	7
Polk				
Ben Anderson				
Cedartown . . . .	12	10	12	10
Walker-Catoosa-Dade				
Gordon L. Hixon				
Ft. Oglethorpe . . . .	33	23	35	28

Whitfield				
M. B. Lumpkin				
Dalton . . . .	36	31	35	29
	309	269	298	262

REFERENCE COMMITTEE RECOMMENDATION—The Committee received the report of the Seventh District Councilor with approval.

HOUSE OF DELEGATES ACTION—Adopted the report of the Seventh District Councilor as recommended by the Reference Committee on motion duly made and seconded.

### Eighth District Councilor

F. G. ELDRIDGE, M.D., *Valdosta*

Several years ago, the Eight District Society members elected to have only one meeting annually and to have a two day meeting over the weekend. As a result, attendance has been very poor.

During the fall meeting, return to two meeting schedule was decided upon. Meeting will be April 12, 1965 in Waycross, Georgia, and efforts to elicit a large attendance will be made.

Dues for the Eight District include necessary funds to defray expense of meetings, hence the smaller societies can entertain the meetings without unnecessary or unusual expense to the local physicians.

Cook and Berrien county physicians have increased in number and have organized the Cook-Berrien County Medical Society thus reducing the South Georgia Medical Society to include Lowndes, Lanier and Echols Counties.

Counties and Secretaries	Members December 31, 1964		Members December 31, 1963	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Altamaha				
Horace L. Morgan				
Baxley . . . .	10	9	9	8
Coffee				
J. W. Herndon				
Douglas . . . .	9	5	11	5
Camden-Charlton				
H. H. Robinson				
Kingsland . . . .	8	8	9	9
Glynn				
Pearl B. Waddell				
St. Simons Island . .	49	45	46	41
South Georgia				
Byron S. Davis				
Valdosta . . . .	57	50	57	51
Telfair				
D. B. McRae				
McRae . . . .	6	6	6	5
Ware				
J. Duncan Farris				
Waycross . . . .	44	36	42	42
Wayne				
Daniel H. G. Glover				
Jesup . . . .	10	9	10	9
	193	168	190	170

REFERENCE COMMITTEE RECOMMENDATION—The Committee received the report of the Eighth District Councilor with approval and noted the comment contained therein, that the Eighth District had tried having only one District Society meeting per year. The attendance was so poor that the former practice of two meetings per year was reinstated.

HOUSE OF DELEGATES ACTION—Adopted the report of the Eighth District Councilor as recommended by the Reference Committee on motion duly made and seconded.



## Ninth District Councilor

CHARLES R. ANDREWS, JR., M.D., *Canton*

It has again been a pleasure and privilege to have served as Councilor for the Ninth District and attention is called to the fact that Dr. Paul Scoggins continues his excellent work as Vice-Councilor and is most exemplary in this role.

Under the excellent leadership of our President Dr. Austin J. Walter, and our outstanding Secretary, Dr. Hamil Murray, the Ninth District continues to be a strong society with excellent programs at its bi-annual meetings in September and April. Our last meeting, as of this report, was held September 1964 at Toccoa at which time program included subjects for GP accreditation courses. Similar scientific sessions have been held at previous Ninth District Meetings. The Ninth District is happy to have with them the doctors from the new counties which now make up the Ninth Congressional District.

Ninth District Councilor has attended all meetings of MAG Council, the Annual Session, and the meetings of the House of Delegates.

Below is a breakdown of the 9th District component societies and their membership strength.

Counties and Secretaries	Members December 31, 1964		Members December 31, 1963	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Blue Ridge				
James M. Haymora				
Blue Ridge . . . .	9	5	8	4
Chattahoochee				
James H. Hunt				
Duluth . . . . .	19	17	19	17
Cherokee-Pickens				
Evan Boddy				
Woodstock . . . .	15	13	14	12
Habersham				
F. O. Garrison				
Cornelia . . . . .	16	13	15	13
Hall				
Leland L. Pool				
Gainesville . . . .	52	45	50	43
Jackson-Barrow				
A. A. Rogers, Jr.				
Commerce . . . . .	16	13	17	12
Rabun				
John E. Fowler				
Clayton . . . . .	4	3	3	2
Stephens				
Charles M. Henry				
Toccoa . . . . .	17	16	19	18
	148	125	145	121

REFERENCE COMMITTEE RECOMMENDATION—The Committee received the report of the Ninth District Councilor with approval.

HOUSE OF DELEGATES ACTION—Adopted the report of the Ninth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

## Tenth District Councilor

ADDISON W. SIMPSON, JR., M.D., *Washington*

As Chairman of Council, I wish to report a successful year for the Tenth District. All component societies have been active with the exception of one. It is my recommendation that the one county society be merged with an adjacent county medical society as it is now a

non-functioning society.

The Tenth District Society held two meetings during the year. The summer meeting was held in conjunction with Dr. Edward Annis' trip to Georgia and his talk to the Richmond County Medical Society. The winter meeting was also held in Augusta where an excellent scientific program was presented to a pitifully few. There were only three components medical societies represented.

I would like to thank Dr. Marion Hubert, Vice Councilor from the Tenth District for taking over for me for those times when I was unable to attend the Councilor's duty.

Counties and Secretaries	Members December 31, 1964		Members December 31, 1963	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	
Crawford W. Long				
Harvey Cabaniss				
Athens . . . . .	57	46	58	47
Elbert-Franklin-Hart				
John N. Shearouse				
Lavonia . . . . .	24	17	22	15
McDuffie				
John W. Lemley				
Thomson . . . . .	7	6	7	6
Oconee Valley				
H. A. Thornton				
Greensboro . . . .	11	8	13	8
Walton				
C. C. Moreland				
Logansville . . . .	11	9	10	8
Warren . . . . .	1	—	1	—
Warren				
H. B. Cason				
Wilkes				
C. E. Pollock				
Washington . . . .	8	6	11	7
	116	92	122	91

REFERENCE COMMITTEE RECOMMENDATION—The Committee received the report of the Councilor of the Tenth District and approved the recommendation of the Councilor, that the Warren County Medical Society be merged with an adjoining county and expressed feelings that it was up to the one physician in Warren County to which county medical society he wished to affiliate with.

HOUSE OF DELEGATES ACTION—Adopted the report of the Tenth District Councilor as recommended by the Reference Committee with the additional recommendation made by the Reference Committee on motion duly made and seconded.

## Tenth District Vice Councilor

M. A. HUBERT, M.D., *Athens*

It has been my pleasure to serve as Vice-Councilor during this past year. The 10th District has had 2 meetings which were well attended. The Councilor has attended all Council meetings, and is doing an excellent job. The Societies of the District have cooperated and tried to carry out the directions from MAG Headquarters. Efforts are being made to get better attendance at the State Meeting.

REFERENCE COMMITTEE RECOMMENDATION—The Committee received the report of the Tenth District Vice Councilor. This was approved with recommendation that the Councilor and Vice Councilor of the Tenth District attempt to improve attendance at the Tenth District meetings.

HOUSE OF DELEGATES ACTION—Adopted the report of the Tenth District Vice Councilor as recommended by the Reference Committee with the additional recommendation made by the Reference Committee on motion duly made and seconded.



## Richmond County Councilor

H. D. PINSON, M.D., *Augusta*

As councilor of the Medical Association of Georgia from Richmond County, I have attended all meetings of this body during the past year. This has been a very eventful year for us and I wish to take this opportunity to state that I think that our Legislative Committee has been very active in its fight of the King-Anderson bill and socialized medicine. I have helped in this matter in every way possible as an individual, although I was not a member of this committee. I think that this continues to be the number one item for our interest for the coming year and I suggest that every member of the Medical Association of Georgia redouble his efforts in this fight.

I have served again this year as Chairman of the Subcommittee on Relative Value Study and we have now completed the major part of this work. My report in regards to this matter will be submitted in a separate report.

Counties and Secretaries	Members December 31, 1964		Members December 31, 1963	
	MAG	AMA	MAG	AMA
	Dues Paying Only		Dues Paying Only	

### Richmond

Stuart H. Prather, Jr.

Augusta . . . . .	247	215	238	209
-------------------	-----	-----	-----	-----

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee received the report of the Richmond County Medical Society Councilor with approval.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Richmond County Medical Society Councilor as recommended by the Reference Committee on motion duly made and seconded.

## Hospital Activities

MILFORD B. HATCHER, M.D., *Chairman*

There have not arisen any problems concerning hospitals during the year of 1964-65. There have not been presented for this Board any specific subjects for study and evaluation. There has been formation of area planning programs throughout the state, and this Board wishes to recommend that as many physicians as possible become active and participate and advise these planning committees.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee received the report of the Chairman of the Hospital Activities Board. In this report it was noted that there has been formation of an "Area Planning Program" throughout the state, and that the Board wishes to recommend that as many physicians as possible become active and participate and advise these planning committees. Dr. Milford Hatcher, Chairman of the Board, appeared before the Reference Committee and emphasized the great importance of the Area Planning Program, the fact that most physicians may not be familiar with their existence, and that these are the committees that have a great say in future planning, use of federal monies, location, types of facilities, all worked out with the Georgia Board of Public Health. After discussion, members of the Reference Committee requested that Dr. Hatcher appear before the House of Delegates to clarify and emphasize this situation to the Delegates.

**HOUSE OF DELEGATES ACTION**—Speaker Walker called on Dr. Milford Hatcher to discuss Area Planning Programs. Linton Bishop, Atlanta, queried Dr. Hatcher as to who is on the Council, and how it is composed. Thomas Anderson, Atlanta, explained how the Atlanta Community Council functioned. Further discussion ensued.

William Dowda, Atlanta, moved (Dowda-Dismuke) to amend the recommendation of the Reference Committee to request that MAG set up a committee to investigate the possibility of having physicians on each Area Wide Planning Committee, and report back to MAG Council in six months on this activity. Further discussion ensued on the motion, and then Speaker Walker called for a vote, and the Dowda-Dismuke motion was approved.

## Blood Banks Subcommittee

JACK C. NORRIS, M.D., *Chairman*

The report of the Subcommittee on Blood Banks is in essence the report of its meeting on February 17, 1965 in Atlanta. Those attending this meeting were the Chairman, Doctors Walters Sheppard, Hugh V. Bell, Jr., Webster A. Sherrer (not a member of the Subcommittee, but representing Menard Ihnen), and J. W. Iseman, Ex-officio member of the Subcommittee. Doctors S. C. Rutland and Menard Ihnen were unable to attend.

The meeting began at 12:45 and ended at 2:45 p.m. A lively discussion of blood bank problems and generalities occupied the first hour and it was agreed that considerable progress was being made in blood banking and blood banking methods in the State of Georgia. Attention was also directed to the activities of the Red Cross blood program for the year 1964. A record peacetime collection of 2,737,300 pints of blood was collected by the Red Cross during last year (1964). It was also noted that the American Association of Blood Banks has inspected and approved more than 1,000 blood banks in the U.S. We in Georgia urge all blood banks to come under this group in the near future; that there also be a more thorough and complete central inventory of blood, which can probably best be done through the Red Cross in order that all blood drawn can be used expeditiously.

Chairman Norris also made reference to the possibility of eventually establishing in Atlanta a \$3,000,000 blood banking facility for the entire Southeastern district, to include space for the Red Cross, with facilities for the manufacture of all blood components as well as blood for transfusions. This shall be explored.

In addition to the above, the Subcommittee makes the following general recommendations:

(1) The Subcommittee and the MAG are urged to give support to H.R. 9238, which states certain acts of nonprofit blood banks do not constitute restraint of trade under the laws of the United States. Representative Weltner has been informed on this bill on June 19, 1964.

(2) The Subcommittee continues to urge all physicians to be well informed about blood banking in order that they may communicate the problems to their patients whenever blood is needed. Continuing education in this is important.

(3) That each blood bank or hospital, if possible, have committees in their hospitals who shall pay serious attention to reactions in order to prevent occurrence of same; and to suggest steps to be taken to conserve the use of blood.

(4) That all blood banks continue to be directed by physicians trained in clinical pathology and blood banking methodology, licensed to practice in the State.

(5) The Subcommittee further goes on record for blood banks to accept accreditation by the American Association of Blood Banks, and disapproves of licensing by State Health Associations and/or the Department of Health.

(6) That all blood banks, hospitals and directors thereof, be reminded of the availability of the AABB depot for frozen rare blood. This office also carries files on rare bloods. Rare type donors wherever located ought to be registered there.



(7) The Subcommittee also suggest and recommends that all hospital labs and blood banks obtain a copy of and familiarize themselves with the booklet entitled "General Principles of Blood Transfusion," published by J. B. Lippincott and Company, Philadelphia, Pennsylvania.

(8) And lastly, all physicians to keep constantly in mind that the routine ordering and administration of blood to patients is old fashion, out of date, dangerous and useless. A critical evaluation of the patients needs is essential in the proper use of blood.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee received the report of the Blood Bank Subcommittee for information and feels that no further action is needed from the House of Delegates at this time.

**HOUSE OF DELEGATES ACTION**—Adopted the Reference Committee recommendation on the report of the Blood Bank Subcommittee.

**Hospital Relations Subcommittee**

MILFORD B. HATCHER, M.D., *Chairman*

There have not been any problems presented to this Subcommittee as regards Hospital Relations during the year of 1964-65. As far as can be ascertained, the relations of hospitals and other related personnel appeared to be coordinated satisfactorily.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee received the report of the Hospital Relations Subcommittee with approval.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Hospital Relations Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

**Resolution No. 3**

LETTERHEAD FOR EACH "MEDICAL STAFF"

B. H. JENKINS

COWETA COUNTY MEDICAL SOCIETY

WHEREAS, the Medical Staff of each Hospital is a distinct part of the organization of each Hospital, and

WHEREAS, the Medical Staff of each Hospital is an organized group of physicians distinct from any other group of physicians, and

WHEREAS, the Medical Staff of each Hospital has letters and communications related specifically to Medical Staff affairs,

NOW, THEREFORE BE IT RESOLVED THAT the Coweta County Medical Society recommends and encourages:

- (1) that the Medical Staff of each Hospital have and use a distinctive letterhead, with at least "Medical Staff" and the name of the Hospital, and
- (2) that physicians writing for the Executive, or for Committees, of the Medical Staff also use this letterhead, and
- (3) that a copy of each letter written on the Medical Staff letterhead be filed with the Secretary of that Medical Staff,

AND FURTHER BE IT RESOLVED THAT our delegate introduce this resolution at the next meeting of the House of Delegates of the Medical Association of Georgia,

AND FURTHER BE IT RESOLVED THAT the

Medical Association of Georgia Delegates be instructed to introduce a similar resolution at the next meeting of the House of Delegates of the American Medical Association.

**REFERENCE COMMITTEE RECOMMENDATION**—Resolution No. 3, entitled "Letterhead for each Medical Staff," was discussed by Dr. Robert M. Webster of Newnan, Georgia, who expressed the opinion that action as proposed by the resolution will improve communication and knowledge both between members of medical staffs of hospitals, and between these and other organizations. He felt that it would also delineate the identity of the medical staff as such; he presented several examples concerning this. It was the feeling of Reference Committee No. 4 that this resolution should be adopted by the House of Delegates and the Committee so recommends.

**HOUSE OF DELEGATES ACTION**—Adopted Resolution No. 3, entitled "Letterhead for each Medical Staff" as recommended by the Reference Committee on motion duly made and seconded.

**Resolution No. 2**

THE PRACTICE OF RADIOLOGY IN HOSPITALS

L. C. DURRENCE

WARE COUNTY MEDICAL SOCIETY

WHEREAS, the practice of Radiology by contractual arrangement with the hospital and collection of the fee by the hospital has the disadvantages of:

- (1) Increasing the problems of hospital-physician relations;
- (2) Giving the radiologist a monopoly which restricts free choice of physician by a patient and restricts free choice by a physician of a consultant radiologist;
- (3) Identifying the radiologist as a hospital employee and his services as hospital services in the minds of the administrator and governing board and patient and insurance carriers; and

WHEREAS, the Radiologists in Memorial Hospital have been sending their bills for their services since June 1, 1962, and

WHEREAS, the Council of the American College of Radiology at the Annual Meeting in February, 1965, declared restrictive covenants or contracts unethical, and urged all ACR members to work toward arrangements where they send their bills for their services, therefore,

BE IT RESOLVED, that the Ware County Medical Society endorse and approve the action of the American College of Radiology, and encourage its members to strive for such arrangements and,

BE IT FURTHER RESOLVED, that this resolution be forwarded to the Medical Association of Georgia and the American Medical Association for approval and implementation.

**Resolution No. 5**

SEPARATION OF HOSPITAL CHARGES AND PROFESSIONAL FEE IN RADIOLOGIC SERVICES PERFORMED IN HOSPITALS

ALBERT A. RAYLE, JR.

FULTON COUNTY MEDICAL SOCIETY  
DELEGATE

WHEREAS, one year ago the Medical Association of Georgia endorsed the "Guide for Hospital-Radiologist Relations," but added the following statement: "It is recommended to radiologists and hospitals that both



consider working toward the eventual replacement of percentage contracts by a fee-for-service basis, with division of the radiologic charge into a professional fee and a hospital charge . . . Until the radiologist is divorced financially from the hospital there inevitably will be conflicts over contractual arrangements. These conflicts could increase if the trends in medical practice and hospitalization insurance practices continued. Placing the radiologists in the same position as the rest of the medical specialists is as fundamental a principle as the others so well expounded by the Georgia Hospital-Medical Council;" and

WHEREAS, in the past year little or no headway has been made toward this goal, and potential or actual conflicts loom larger, and the Medical Association of Georgia therefore feels it necessary to express its conviction and its recommendation even more firmly and explicitly, therefore,

BE IT RESOLVED, that the Medical Association of Georgia strongly recommend to hospitals and radiologists that during the next year both consider revising existing contractual arrangements so that charges for radiologic services (both diagnostic and therapeutic) are separated into a charge for professional services and a charge for hospital costs, and

That what constitutes a reasonable charge for hospital costs is a decision which should be made by the hospital; what constitutes a reasonable charge for his professional services to the patient is a decision which should be made by the radiologist, and

That under this premise, the radiologist ordinarily should be expected to submit and collect his own bills, as do other physicians; that a less desirable alternative, where the hospital collects the full charge and remits to the radiologist his share, would be acceptable if (1) the radiologist sets the charge for his professional service to each patient, (2) the name of the radiologist and the exact charge for the professional services (as separate from the hospital charge) is specified on the bill, and (3) the radiologist compensates the hospital only for its realistically accounted costs in collecting his bills, and

That the Medical Association of Georgia believes that the principle of separation of radiologic charges is not only sensible but is a basic necessity for long range stability and harmony in hospital-radiologist relations, and

BE IT FURTHER RESOLVED, that if this resolution meets the approval of the MAG, that a copy be sent to every hospital in Georgia and to every radiologist who performs radiologic services in hospitals in Georgia.

**REFERENCE COMMITTEE RECOMMENDATION**—Resolution No. 2—Practice of Radiology in Hospitals and Resolution No. 5—Separation of Hospital Charges: These two resolutions were considered jointly because of the similarity of content. There was very lengthy discussion concerning these two resolutions. Dr. Neal Yeomans of Waycross appeared before the Committee for discussion, as did Dr. David Robinson of Savannah, presently Secretary of the Georgia Radiological Society. Dr. Albert Rayle, author of Resolution No. 5, also appeared before the Reference Committee. After much discussion, Reference Committee No. 4 felt that both Resolutions No. 2 and No. 5 should be accepted for information with neither approval or disapproval. We recommend that the Georgia Radiological Society poll its entire membership by mail concerning these resolutions and submit the results of this poll to the House of Delegates at the 1956 session for further consideration. The Reference Committee was advised that the Georgia Radiological Society in its meeting yesterday, May 2, unanimously endorsed both of these resolu-

tions, except for a deletion in Resolution No. 5 beginning in paragraph No. 5 after the first sentence, which reads only "that under this premise the radiologist should be expected to collect his own bills, as do other physicians." The rest of the paragraph was deleted.

**HOUSE OF DELEGATES ACTION**—Speaker Walker recognized Dr. L. C. Durrence of Blackshear, who moved (Durrence-Whittle) to approve the original resolution No. 2, entitled "Practice of Radiology in Hospitals" in place of the Reference Committee's recommendation on this resolution. After discussion, Speaker Walker called for a vote and the House voted to approve the original Resolution No. 2 in place of the Reference Committee recommendation.

Speaker Walker then recognized Dr. Albert Rayle, Atlanta, who moved that the House adopt the original Resolution No. 5 in place of the Reference Committee recommendation but to include the deletion noted in the Reference Committee Recommendation. This motion was seconded by Luther Vinton, Decatur. After discussion, Speaker Walker called for a vote and the motion by Dr. Rayle was approved, in that the original Resolution No. 5 was adopted by the House with the deletion noted in the Reference Committee Recommendation.

It was then moved by Reference Committee No. 4 Chairman, J. T. Christmas, Vienna, and duly seconded that the report of the Reference Committee be approved as amended, and it was so ordered.

## Report of Reference Committee No. 5

W. W. Osborne, Savannah, Chairman

*(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendations for action pursuant to it taken by the House of Delegates.)*

Reference Committee No. 5 met in the Embassy Room of the Augusta Town House Motor Inn, Augusta, Georgia, at 2:30 p.m., on May 3, 1965. Members present were: W. W. Osborne, Savannah, Chairman; C. Peter Lampros, Clayton, Vice Chairman; M. Freeman Simmons, Decatur, Secretary; Ollie McGahee, Jesup; M. H. Whittle, Lyons; L. C. Durrence, Waycross; M. K. Cureton, LaFayette; Albert A. Rayle, Atlanta; and Charles R. White, Macon.

### Professional Conduct

LUTHER H. WOLFF, M.D., Chairman

The Professional Conduct Committee was confronted with one complaint requiring its attention during the past year. An investigation into the facts in the case was made and the matter was ultimately settled amicably, and I believe to the mutual satisfaction of all parties concerned.

At the request of the President of MAG the Committee undertook an additional activity this past in the field of medical ethics. It was the feeling of the President that the MAG membership would appreciate having a better, more thorough knowledge of the field of medical ethics and accordingly requested the Committee on Professional Conduct to consider this additional activity.

The Committee met on this matter and selected for distribution certain opinions of the AMA Judicial Council, which in the estimation of the Committee, were those in most need of better understanding.

As of the time this report is being written the



mechanics of distribution have not been worked out. However, it is hoped that the efforts of the Committee will bear fruit in the near future.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee approves this report from the Professional Conduct Committee.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Professional Conduct Committee as recommended by the Reference Committee on motion duly made and seconded.

**Annual Session**

THOMAS Q. SPITZER, M.D., *Chairman*

Plans were formulated and carried out for this year's Annual Session. In order to rekindle interest in the meeting and increase attendance the format of previous years was revised.

The major change was shortening the meeting by one day. The General Business meeting and House of Delegates Session was moved from Sunday until Monday, to be followed by the closing session on Tuesday. It was felt that the elimination of the two day delay between delegates meetings would encourage more of them to attend both meetings.

Attempt was made to combine those speciality society meetings which are most closely allied to make for a more interesting scientific program.

Streamlining to increase attendance was this year's aim.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee approves with commendation this report. A recommendation to continue the same plan with the addition that at the first session a joint meeting with the Woman's Auxiliary be held subject to their approval. This would enable the members to hear the President-Elect of the Woman's Auxiliary as well as the President-Elect of MAG, Monday morning at the first session so that their planning could be considered by the House of Delegates. This would also provide a larger audience for the welcoming dignitaries.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Annual Session Board as recommended by the Reference Committee with the additional recommendation made by the Reference Committee on motion duly made and seconded.

**Governmental Medical Services**

LUTHER H. WOLFF, M.D., *Chairman*

A called meeting of the Board of Governmental Medical Services of the Medical Association of Georgia was called to order by Chairman Luther H. Wolff at 11:00 a.m. September 13, 1964 at the Medical Association of Georgia Headquarters Building, Atlanta.

Those members of the Board present were: Drs. Luther H. Wolff, Columbus; Eugene Griffin, Atlanta; W. Bruce Schaefer, Toccoa. Also present was Mr. James M. Moffett, MAG Staff.

The Chairman opened the meeting by explaining the need of the various Subcommittees under this Board to plan for activities during the coming months. He particularly stressed the need for close cooperation between the Subcommittees where the functions of some overlap with the functions of others. Dr. Wolff then reviewed the multiplicity of arrangements under which the State Health Department presently purchases needed medical services for each of its various programs.

General discussion followed on this matter. Three main points emerged. These points are: (1) The Board recommends against the "fee for service" principle due

to the excessive cost involved. In arriving at this recommendation Dr. Schaefer made the point that one of our strongest defenses against "socialized medicine" is the fact that physicians give of their services in the treatment of indigent patients and suggested that the present system be retained. The two remaining points brought out in discussion were alternative recommendations. These were: (1) That a system of indemnification of physicians be set up whereby physicians would be paid on a set fee per hour; or, (2) leave the system "as is." It was the consensus that it was best to leave the present system unchanged, with the reservation that future changes might be justified should Federal control of medical care continue its present trend.

The Subcommittees under the Board were then discussed in turn and the following activities recommended for each:

**CRIPPLED CHILDREN:** The Board recommended to this Subcommittee that it schedule a meeting with representatives of the Children's Bureau of the Department of Health, Education and Welfare, the Crippled Children's Service of the State Health Department and its counterpart in the State Department of Family and Children Service. The purpose of such a meeting would be to improve liaison and for a mutual exchange of ideas.

**MEDICAL INDIGENCY:** The Board commended the work of this Subcommittee and took cognizance of the difficult job it has to perform. It recommended that the Subcommittee continue its study of the problems relating to eligibility and come up with a feasible plan for the establishment of guidelines in this field. It also recommended that such findings and recommendations as the Subcommittee may make be reported to the MAG Executive Committee, through the Board of Governmental Medical Services as soon as possible.

**DISASTER MEDICAL CARE:** The Board recommended that this Subcommittee plan to meet with the Georgia Hospital Association and the Hospital-Medical Council in an effort to perfect more workable disaster care plans. It also recommended that the Subcommittee undertake to encourage County Medical Societies to initiate their own disaster plans and to activate (dry run) such plans at least once each six months. The Board recommended that such plans include provision for securing "outside" assistance and detailed plans for the adequate and productive use of such "outside" assistance when it arrives on the scene of the disaster.

**MATERNAL AND INFANT WELFARE:** Dr. Griffin, Subcommittee Chairman, explained to the Board that his group was presently working with the Department of Family and Children Service and the Junior Chamber of Commerce on a *food surplus program* designed to minimize mental retardation through better nutrition for pregnant women. He further explained that his Subcommittee was working on a program to help prevent rather than treat mental retardation by encouraging the expenditure of money in the research of causes as opposed to spending all available money in the study of treatment.

He also advised that the Subcommittee was concerned over the laxity of the penalty provisions of the abortion laws in Georgia and suggested that his group may in the future recommend changes in Georgia's abortion laws in an effort to discourage traffic in illegal abortion.



The Board approved the activities of this Subcommittee and recommended that this group meet soon with the Mental Health Committee inasmuch as their function has some overlapping aspects.

Dr. Griffin further advised the Board that where his group at one time considered maternal mortality their biggest concern, they no longer feel this is the case. Accordingly, they are shifting their emphasis to other fields such as mental retardation. He pointed out that the Subcommittee is tying its efforts to educate the public of the need for pre-natal care together with its work on the food surplus program. By giving pregnant women surplus food when they come to clinics they then have an opportunity to give such pre-natal care as may be indicated.

**PUBLIC HEALTH:** The Board recommended that this Subcommittee should meet with the State Board of Health for the purpose of improving liaison with the Board.

**REHABILITATION:** The Board recommended that this Subcommittee continue to work with all Governmental agencies involved in rehabilitation work such as alcoholic rehabilitation and crippled children.

**VETERANS AFFAIRS:** The Board took cognizance of the fact that this Subcommittee has no "ever-present" function, but is called upon from time to time to handle complaints directed at the Veterans Administration. For this reason it recommended that the Subcommittee continue to function as at the present time to provide the necessary machinery when problems do arise.

**SCHOOL CHILD HEALTH:** The Board recommended that this Subcommittee continue its annual presentation of the Conference on the Medical Aspects of Sports. It also recommended that it consider developing programs for administration by school officials of physical exercise for school children, immunization and nutrition. It further recommended that the Subcommittee consider an effort to have included in school curriculums a study of basic health knowledge to include an anti-smoking program.

The Board also recommended that the Subcommittee undertake to insure that all athletic contests at the school level be attended by a physician and further suggested to the Subcommittee that interested parties be encouraged to work on the development of more adequate athletic equipment as a means of minimizing injuries.

A final recommendation of the Board was that this Subcommittee develop a program designed to screen the lower one-third of the class in all school for possible defective hearing and vision.

There being no further business before the Board the meeting was adjourned.

**REFERENCE COMMITTEE RECOMMENDATION—**The Committee approved the report of this board with the amendment that the fee-for-service principle should not be abandoned in favor of "hourly wage." Physicians' services may be given gratis and physicians doing so should be commended but basic fee-for-service idea is fundamental. Any honorarium should be considered as expense and not fee-for-service.

**HOUSE OF DELEGATES ACTION—**Adopted the report of the Governmental Medical Services Board as recommended by the Reference Committee with the additional recommendation made by the Reference Committee on motion duly made and seconded.

### **Disaster Medical Care Subcommittee**

VIRGIL B. WILLIAMS, M.D., *Chairman*

The Subcommittee on Disaster Medical Care met

with Dr. George W. Paschall, Jr., of Raleigh, N.C. representing the American Medical Association Committee on Disaster Medical Care. At this meeting problems of our Disaster Medical Care Committees were discussed.

The Chairman of the committee attended the Disaster Medical Care Seminar in Chicago in 1964. Information gained at this meeting has been most valuable in formulating plans of the Subcommittee on Disaster Medical Care.

At the present time we are experiencing good cooperation with county societies in setting up teams of five doctors to respond immediately to medical needs in disaster areas. Splendid liaison has been established with State Civil Defense authorities to aid in transportation and housing of these teams where applicable. Communications still presents a problem.

The Chairman of this committee has been ready at all times to assist in planning Disaster Medical Care Programs. Information concerning Disaster Medical Care programs has been distributed to county societies requesting such.

**REFERENCE COMMITTEE RECOMMENDATION—**The Reference Committee approves the report of the Disaster Medical Care Subcommittee.

**HOUSE OF DELEGATES ACTION—**Adopted the report of the Disaster Medical Care Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

### **Maternal and Infant Welfare Subcommittee**

EUGENE L. GRIFFIN, M.D., *Chairman*

#### **MATERNAL SECTION**

Under the chairmanship of Doctor Eugene Griffin this Subcommittee met quarterly to review the cases of maternal deaths occurring in the State of Georgia as well as residents of the State who expired outside the State in association with childbirth. This Subcommittee studies every case of maternal death occurring in Georgia and sends a critique of the handling of the case to the physician in attendance. The response to our questionnaires is better. Improvement is needed, however, so that the gross findings at autopsy, when done, are included, also any additional pertinent information is requested in the remarks section. The physician and patient identity is kept anonymous to the members of the Subcommittee.

Seventy-five (75) deaths associated with pregnancy were reviewed. Fifty-three (53) of these were classifiable as deaths attributable to pregnancy either directly or indirectly. The leading cause of death was infection (16). Eleven of these were associated with abortion. The second most common cause was toxemia (14). The third leading cause was hemorrhage (13). The large number of deaths due to infection associated with abortion probably indicates that most of these were secondary to criminal abortion.

There were 99,360 live births in Georgia in 1963 giving a maternal death rate of 5.3 per 10,000. The maternal mortality has decreased over the past four years from 8.9 in 1959 to 5.3 in 1963. The estimated rate for the nation as a whole in 1963 was 3.2 per 10,000 live births.

There were 7,743 live births without medical attendant for a percentage of 7.8 of the total. This is of much concern to the Subcommittee even though it is



an improvement over 1962 both in numbers, 8,677, and in percentage, 8.8 Another matter of concern is the premature rate. It has increased persistently and substantially over the years from a rate in 1947 of 60.8 per 1,000 live births to 95.3 per 1,000 in 1963. This increase has been reflected each year without exception.

It is gratifying that in 1963 five additional counties worked out a plan for delivery by a physician in a hospital of the low income, high risk group of obstetrical patients. This was accomplished through diligent effort and close cooperation of the local physicians, hospitals and health departments of the communities. It is hoped that plans of this type will be considered by all local medical societies in Georgia. Talmadge Memorial Hospital continues to accept complicated obstetrical patients from any part of the State on prior notification and referral by a physician.

The live births to unwed mothers continues high in Georgia. The rate in 1963 was 100.6 per 1,000 live births as compared to the U. S. rate in 1960 of 56.9 per 1,000 live births. It is interesting to note that over half has been the second or subsequent live birth.

The Subcommittee also took under consideration for necessary action other factors related to maternal and infant health and welfare during this period. As noted in the last annual report, the committee had been following closely H.R. 3386 pertaining to the improvement of Maternal and Child Health and supported this through the Medical Association of Georgia. This bill resulted in Public Law 88-156 which included grants for special Maternal and Infant Care projects and research projects. During the first half of 1964, Congress appropriated monies to support this law and the committee encouraged and supported the development of such projects in Georgia. One such project was accomplished and put into actual operation in eleven (11) counties through the health department in association with the Medical College of Georgia. One research project was established for two (2) counties and one project for Maternal and Infant Care was well formulated in preparation for final approval. The Maternal and Infant Care project was supported financially by the Children's Bureau and the State and local health departments. The Subcommittee is intensely desirous that future such projects be developed and is quite proud that Georgia had one of the first Maternal and Infant Care projects approved under this legislation.

In our last annual report, we noted that the Subcommittee was cooperating with the Junior Chamber of Commerce, State Department of Health, Department of Family and Children Services, Department of Agriculture, and the Department of Education in the promoting of surplus food commodities for the needy expectant mothers throughout the State. This has progressed to the extent that the program is being utilized in thirty-nine (39) counties. The effort to have more counties finance and administer this program will be continued.

The Subcommittee has also considered and supported the programs of Family Planning and the updating of methods of pregnancy-spacing to include the more recent methods that are considered good current medical practice. The Subcommittee has continually emphasized that Family Planning should be a complete program in that it should consider the infertility problems as well as the need for pregnancy-spacing in accordance with the Patients' desires, moral and religious beliefs.

A State Sterilization bill was written in cooperation with Mr. Moore, our legal advisor. The Subcommittee feels that there is a very urgent need for such legislation. The bill has been referred to a Senate committee of the legislature. The Subcommittee requests the full cooperation of every physician in the State to help us get this bill through the legislature at its next session.

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee approves with commendation the report of the Maternal and Infant Welfare Subcommittee.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Maternal and Infant Welfare Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

### Public Health Subcommittee

R. W. EDENFIELD, M.D., *Chairman*

In response to your letter of February 15th regarding the annual report on the Subcommittee on Public Health, I regretfully state that this committee has no report to make. During the past two years, I have tried to keep in contact as much as possible with the activities concerned with this committee. However, in the last year due to the legislative changes and other activity at the state capital, I believe that most of the problems that might have come under the heading of this committee have been handled by the Executive Committee in Atlanta. I believe this is as it should be in that they are in more close contact with the problems there.

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee approves this report of the Public Health Subcommittee.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Public Health Subcommittee as recommended by the Reference Committee on motion duly made and seconded.

### Legislation

J. FRANK WALKER, M.D., *Chairman*  
National Legislation

JOHN A. BELL, JR., M.D., *Chairman*  
State Legislation

The legislative affairs of MAG continue to be the most time consuming and, perhaps, the most important project area undertaken by the Association during the past several years. The most recent 12 months period is no exception. Because of the complexity of legislative affairs your Board is organized with two Subcommittees working in separate levels of legislative activity; namely, National Legislation and State Legislation. In some instances the functions of the two Subcommittees overlap. For the most part, however, they remain separate and this report is made by Subcommittee.

### NATIONAL LEGISLATIVE ACTIVITY

Social Security medicine has dominated all consideration of national legislative activities during the past 12 months. The medical profession won a brief reprieve in late 1964 following the inability of Congressional advocates of King-Anderson type legislation to force this bill out of a "deadlocked" Senate-House Conference Committee as a campaign bonanza for the incumbent Administration.

However, in early 1965, the King-Anderson bill was again introduced. An indication of its importance to the Administration can be gained from the number as-



signed this bill both in the House and Senate: In the House it's H.R. 1 and in the Senate, S. 1.

As of the time this report is being written legislation in the field of health care for the aged still resides in the Ways and Means Committee of the House of Representatives. All consideration of this legislation during 1965 by the Committee has been closed to the public. Official announcements by the Committee have been scarce and the contents of any bill which may be reported out by the Committee is speculation. (It is anticipated at this writing that a Supplemental Report on whatever bill may emerge from the Committee will be made to the House to accompany this Annual Report.)

Your Subcommittee on National Legislation has remained extremely active during the past year in an effort to discourage enactment of so-called "medicare" and in an equal effort to promote the passage of Elder-care—the health care plan sponsored by the AMA.

Special pamphlets have been prepared by MAG and the widest possible distribution sought by the Subcommittee on National Legislation. The Subcommittee has also continued to encourage, with moderate success, the development of a Speakers Bureau and has sought to fill all possible speaking engagements. Emphasis has been placed on letter campaigns on the part of physicians and more importantly between the laity and Members of Congress.

MAG's sixth Annual Congressional Luncheon, held at the U.S. Capitol in Washington, was attended this year by every member of the Georgia Delegation in the House and Senate, with the exception of Senator Russell who was, at the time of the luncheon, confined to bed at Walter Reed Hospital. An able member of the Senator's staff represented him and this was the first "100 percent" attendance luncheon which MAG has held in many years. This annual luncheon, customarily held in late spring, was given in February of this year. As in years past it is one of the highlights of the MAG legislative program, and it was agreed among those who attended that this luncheon was well timed and generally productive of better rapport and understanding between our Members of Congress and Georgia physicians.

## STATE LEGISLATIVE ACTIVITY

A full legislative calendar occupied the time and efforts of the Subcommittee on State Legislation during the 1964 session of the General Assembly. The proposal attracting the most attention was the Appropriations Act for the two year budget period of 1965-66 and 1966-67. MAG sought, unsuccessfully, to persuade the legislature to increase the budget of the Department of Family and Children's Services during the 1965-66 year by \$1.2 million for the implementation of the MAA phase Kerr-Mills. While not successful in this endeavor, the General Assembly did appropriate a similar amount for the implementation of MAA Kerr-Mills effective July 1966.

On the positive side of the legislative ledger, MAG sponsored legislation in the field of anti-child abuse was enacted. The bill provides for the mandatory reporting of suspicious cases of child abuse by physicians and others. It further provides for civil and criminal immunity to those required to make such reports, provided, of course, that reporting of these cases is done in good faith. This bill was specifically requested by the 1964 MAG House of Delegates.

Other bills in which MAG either sponsored or took an active interest, but which failed of enactment include: voluntary sterilization, drivers license examinations for people age 65 and over, certain changes in laws relating to marriages, and fluoridation of Atlanta's water supply.

MAG opposed the following bills: full practice privileges for osteopaths, creation of a basic science board, a stringent post mortem bill, and a bill to strip the Board of Medical Examiners of its power to determine which medical schools meet the standards necessary to insure good medical practice in Georgia.

## COMMENDATIONS

Many people have contributed toward the success of the MAG legislative program during the past year, and the Legislative Board and its Subcommittees would like to acknowledge a debt of gratitude to them all. During the 1965 session of the General Assembly there were six physicians who were members of the House of Representatives—the largest number of any State in the Union. They were: Doctors Grady Coker, Canton; Frank Holder, Eastman; Carl Savage, Montezuma; John Acree, Hiawassee; Charles Watkins, Ellijay, and A. Sidney Johnson, Elberton. Your Board wishes to pay a special tribute to these men, who not only recognize the importance of legislative affairs, but who have given freely of their time and talent in this regard.

The Legislative Board would also like to say a well deserved "thank you" to Mr. John Moore, MAG legal counsel for the many hours of valuable assistance he gave to the Association's legislative program.

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee approves with commendation the report of the Legislation Board, and recommends that the Congressmen supporting the bill to recommit H.R. 6675 should be commended by the membership at large.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Legislation Board as recommended by the Reference Committee with the additional recommendation made by the Reference Committee on motion duly made and seconded.

## Special Activities

JOHN S. ATWATER, M.D., *Chairman*

The Board of Special Activities has continued to work in liaison with the State Board of Medical Education listing physicians and localities seeking placement. This is done through the MAG Physicians' Placement Bureau.

The Subcommittee on Health Care for the Aging has continued its activities. Throughout the year members have continued to appear before various civic, social and professional organizations on behalf of the aging program and the position of medicine in such activities. The Health Care of the Aging Subcommittee has continued its cooperation with other organizations through the Georgia Joint Council to Improve the Health Care of the Aged. The Health Care of the Aging Subcommittee has sponsored a dinner meeting of this organization during the year. In addition several members of the Subcommittee have participated in both the local and national conferences sponsored by the American Medical Association and American Nursing Home Association on Long Term Care.

It is hoped that the continued efforts of this Subcommittee and Board will produce an even greater



awareness of the problems facing the private practice of medicine. It is recommended that the Medical Association of Georgia continue its support of the work of this Board and Subcommittee.

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee approves the report of the Special Activities Board.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Special Activities Board as recommended by the Reference Committee on motion duly made and seconded.

**Late Report No. X-1**

**SECOND DISTRICT VICE COUNCILOR**

**J. C. BRIM, PELHAM**

This is to report that the Vice-Councilor of the Second District Medical Society has attended the county meetings, district meetings, and meetings of surrounding county and district societies when possible.

I wish to say that I have made an effort individually as well as collectively to distribute in my area pertinent information relative to the councils actions and advice concerning problems of interest to the Medical Association.

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee approves the report of the Second District Vice Councilor.

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Second District Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

**Late Report No. X-3**

**SUBCOMMITTEE ON CANCER**

**ROBERT C. PENDERGRASS, Chairman**

The Subcommittee on Cancer met at the headquarters of the MAG on January 24, 1965, on February 21, 1965, and again on March 7, 1965. In addition two other subcommittee meetings were held.

The major subjects for discussion were as follows:

The use of old age assistance funds for the treatment of cancer patients over the age of 65. It was proposed by the old age assistance people (the Department of Welfare and Children Services) that cancer patients over the age of 65 not necessarily be referred to hospitals with approved cancer programs, but that they might be treated in any one of the 145 hospitals around the state which were approved for old age assistance. The idea behind this seemed to be to get further funds from OAA for the treatment of cancer patients. Since it was felt that the needs of the cancer patient might be more effectively taken care of by those hospitals with approved cancer programs, the subcommittee on Cancer voted to recommend to the Executive Council of the Medical Association of Georgia that the present system of handling patients through State-Aid Cancer Clinics with approved programs be continued. I am enclosing a copy of the committee report to this effect. (For Reference Committee.)

Other matters considered were the question of whether or not a program of patients who had coverage under the American Family Life Assurance Company should be offered the possibilities of a free papanicolaou smear, the material to be collected by the patient, and sent in to the company. No charge was to be made for the examination. There was considerable discussion on this point. It was agreed by the committee that

there was actually nothing unethical about this method of collecting pap smears but it should be emphasized to the patient that this does not constitute a complete examination for cancer and that this should be emphasized to the patients.

At the last meeting of the committee, it was decided to present the findings to the Executive Committee of the Medical Association of Georgia and also to the Executive Council of the Medical Association of Georgia. I was unable to be present at these meetings because of illness but Dr. Robert Brown represented the committee together with several other members. No final action was taken by the Executive Council on this matter and it was felt best to delay any action until the outcome of the pending federal legislation on Medicare was known. I am sorry that this material did not reach you in time to be incorporated in the printed notes to the members of the House of Delegates but this is my first opportunity to get such a report to you. If there are any further questions regarding this report, please phone me and I will get them to you immediately.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee approves this report with the amendment that the sentence "The idea behind this seemed to be to get further funds from OAA for the treatment of cancer patients" appearing in paragraph 3, to be deleted, and that an additional paragraph be included as follows: "It is recommended that cancer patients over 65 with acute conditions related to their disease, or who are terminal and therefore not acceptable by the State Aid Cancer Program, be admitted to any hospital approved by OAA."

**HOUSE OF DELEGATES ACTION**—Adopted the report of the Subcommittee on Cancer as amended by the Reference Committee on motion duly made and seconded.

**Late Report No. X-4**

**SCHOOL CHILD HEALTH SUBCOMMITTEE**

**JACK HUGHSTON, Chairman**

This committee, following the recommendations of the House of Delegates of the AMA and those of the American Association for Health, Physical Education and Recreation, and believing that physical education in schools and colleges should be an integral and basic part of such educational institutions, has undertaken a study of the ways and means of implementing compulsory physical education in Georgia Public Schools.

The committee feels that participation in soundly administered physical education programs can contribute significantly to an increasing health consciousness and a better directed desire for a dynamic life. Also, potent motivational qualities that demand self discipline with respect to health practices can be gained.

The Committee therefore offers the following resolution to the Medical Association of Georgia.

Whereas, The medical profession has helped to pioneer physical education in our schools and colleges and thereafter has encouraged and supported sound programs in this field; and

Whereas, There is increasing evidence that proper exercise is a significant factor in the maintenance of health and the prevention of degenerative disease; and

Whereas, Advancing automation has reduced the amount of physical activity in daily living, although the need for exercise to foster proper development of our young people remains constant; and

Whereas, There is a growing need for the development of physical skills that can be applied throughout



life in the constructive and wholesome use of leisure time; and

Whereas, In an age of mounting tensions, enjoyable physical activity can be helpful in the relief of stress and strain, and consequently in preserving mental health; therefore be it

Resolved, That the Medical Association of Georgia through its various committees and its constituent and component medical societies do everything feasible to encourage compulsory instruction in physical education for all students in our Georgia Schools.

The committee has also formed a Joint Planning Committee for an educational Anti-Smoking Campaign. Representatives of the Medical Association of Georgia, the Georgia Heart Association, the Georgia TB Association, Georgia Cancer Society, State Department of Education and State Health Department met April 22 to plan integration of efforts to educate the school children of Georgia in the potential health hazard of smoking.

In taking further action, the committee has sent the following recommendations to Mr. Sam Banks, Secretary, Georgia High School Coaches Association:

I. That the physical examination forms that are now in use by most high schools in Georgia be improved.

II. That "play-off" games be limited to no more than one during a school week and no more than two in a seven day period.

III. That a pilot program of girls basketball be instituted in which girls are allowed to play "full-court" or by rules which will require more physical activity and at the same time speed up the game.

Again, through the Committee, the Medical Association of Georgia sponsored a postgraduate course on "The Medical Aspects of Sports." A sizeable group of coaches, physicians and trainers gathered in Atlanta, August 7, 1964, at the Academy of Medicine and heard speakers on "Technique of Field Examinations and Decisions," "The Sprained Ankle," "Pulled Muscles," and "Injury Prevention, Conditioning of Athletes." The guest speaker, Dr. Marcus Stewart, Orthopaedic Consultant for Ole Miss and Memphis State University, spoke on, "The Knee in Athletes and the Requirements of Return to Athletic Participation—Rehabilitation."

Plans are well underway for the next Medical Aspects of Sports meeting which will be held Thursday, August 5, 1965, and Friday, August 6, 1965. Indications are that this will be the biggest Sports Medicine meeting ever held in Georgia. Distinguished authorities have been invited to discuss such topics as: recurrent dislocations of the shoulder, open repair of complete ligament tears of the ankle, knee injuries in athletes and hot weather precautions.

The committee has undertaken an evaluation of the current policy regarding physical examinations for school children, but at this time has nothing to report.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee approves the report of the Subcommittee but recommends a change in paragraph 9 as follows: "Resolved that the Medical Association of Georgia through its various committees and its constituent and component medical societies do everything feasible to encourage compulsory instruction in physical education for all physically qualified students as determined by a physician."

**HOUSE OF DELEGATES ACTION**—Adopted the report of the School Child Health Subcommittee as amended by the Reference Committee on motion duly made and seconded.

## Supplemental Report of Legislative Board No. B

### STATUS REPORT ON "MEDICARE" LEGISLATION

JOHN A. BELL, JR., *Chairman, Legislative Board*,  
and J. FRANK WALKER, *Chairman*,  
*National Legislative Subcommittee*

At the time the annual legislative report was written the so-called "medicare" bill was still pending in the Ways and Means Committee of the House. For this reason it was impossible to report to the MAG Delegates what provisions would be included in this bill, when and if it passed the House. As you know, it passed the House by a vote of 313 to 115, on April 8, 1965.

As passed by the House, the bill contains a major portion of the King-Anderson bill with: Up to 60 days of hospitalization; 20 days of nursing home care; outpatient hospital diagnostic services; and post-hospital home health services. This portion of the bill would be financed by a new and separate "hospital insurance trust fund" funded by an additional tax on an increased Social Security wage base.

Part two, the Byrnes portion (so named for its sponsor Congressman John Byrnes) of H.R. 6675 would pay 80 percent of the cost of physicians' services after an annual deductible of \$50 was satisfied. It would also provide: Up to 60 days of care in a mental hospital; up to 100 home health service visits; and various medical and health services as well as prosthetic devices. This program would be financed by a \$3 per month contribution by those over age 65 and would be matched by a similar Federal contribution.

The third part of the bill would expand the Kerr-Mills program to include all other public assistance programs under the Social Security Law to which the Federal government contributes funds.

In addition, the bill provides a 7 percent across-the-board increase in Social Security cash retirement benefits and brings interns, residents, and self-employed physicians under the compulsory provisions of the Social Security Act. All told, H.R. 6675 will increase the employee and employer Social Security tax from the present maximum of \$174 each per year to a maximum of \$369.60 each per year, in 1987.

Total annual cost beginning in the first full year of operation (1967) will be \$6 billion.

Immediately prior to passage of this bill by the House, a motion was made to recommit the bill and substitute in its place another bill which included many of the features of the AMA sponsored Eldercare bill. On this important vote the following Georgia Congressmen voted to support the position of the Medical Association of Georgia and their local physician-constituents:

Rep. G. Elliott Hagan, Savannah, 1st District  
Rep. Maston O'Neal, Bainbridge, 2nd District  
Rep. Howard H. (Bo) Callaway, Pine Mountain, 3rd District

Rep. John J. Flynt, Griffin, 6th District  
Rep. John W. Davis, Summerville, 7th District  
Rep. Russell Tuten, Brunswick, 8th District  
Rep. Robert Stephens, Athens, 10th District

This bill, H.R. 6675, is now pending in the Senate Finance Committee. Public hearings are to be held.

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee approves the Supplemental Report of the Legislative Board No. B entitled "Status Report on 'Medicare' Legislation"



with commendation for the excellent work done during the past year by this committee.

**HOUSE OF DELEGATES ACTION**—Adopted the Supplemental Report of the Legislation Board No. 8 entitled "Status Report on 'Medicare' Legislation" as recommended by the Reference Committee on motion duly made and seconded.

## Resolution No. 1

### PREMARITAL EXAMINATION

FLOYD DAVIS

WARE COUNTY MEDICAL SOCIETY

WHEREAS, Georgia law 53-215 to 53-224 relating to PREMARITAL EXAMINATION for syphilis is now outdated and no longer provides an effective tool for case finding of infectious syphilis, and

WHEREAS, officials of the Georgia Department of Public Health including the Director of the department and the Chief of the V.D. Control Section have recommended repeal of this law, and

WHEREAS, most members of the medical profession have accepted the blood test as evidence of infectious syphilis and do not perform any physical examination and

WHEREAS, the above stated law has resulted in a "Blood Test Racket" in which several members of the Medical Association of Georgia participate in violation of ethical standards of this Association and the American Medical Association, and

WHEREAS, this "Blood Test Racket" along with the so-called "Quickie Marriage Mills" in certain areas of Georgia have caused the entire state of Georgia to be held in ridicule,

NOW, THEREFORE, BE IT RESOLVED by the Ware County Medical Society that the Medical Association of Georgia develop and sponsor legislation in the next General Assembly to repeal said laws, chapter 53-215 through 224.

AND BE IT FURTHER RESOLVED THAT the Medical Association of Georgia go on record as favoring adoption of a mandatory three day waiting period between application and issuance of marriage licenses with no exceptions.

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee disapproves this resolution—Premarital Examination. This Resolution was rejected in the light of recommendations from the State Health Department, Venereal Disease Branch of HEW, and others, that the three day waiting period is needed and that dropping the blood test requirement would be premature at this time.

**HOUSE OF DELEGATES ACTION**—Adopted the Reference Committee Recommendation in disapproving Resolution No. 1—Premarital Examination.

## Resolution No. 7

### COMPULSORY STATE MEDICINE

CHARLES EBERHART

FULTON COUNTY MEDICAL SOCIETY  
DELEGATE

WHEREAS, the medical profession desires to reaffirm its adherence to the Principles of Medical Ethics of the American Medical Association, particularly Section VI, which states "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care," and

WHEREAS, we subscribe to the idea that doctors of medicine can, and have, and will do more to promote the best quality of medical care for the greatest number of people under our traditional system of individual freedom, free enterprise, and free market economy; and

WHEREAS, we recognize the fact that historically the quality of medical care declines under the administration of any socialist or state regime, and

WHEREAS, we have with patience (albeit at times with misgivings and reticence) acquiesced in schemes which have promoted third party intrusion into the doctor-patient relationship, and

WHEREAS, as we justifiably suspected, we have thereby encouraged those whose purpose for years has been to make all medical care a federal function and all medical personnel federal employees, and

WHEREAS, the purposes of the "socializers" under their Fabian program of gradualism are being hastened by the present federal administration in their program of Social Security medicine for a segment of our population; later (by their own admission) to be expanded to all our population; and

WHEREAS, we feel that to cooperate in federal social security medicine, no matter how disguised, is morally wrong because it will inevitably lower the quality of medical care, and will make patients, and doctors, and all medical personnel subservient to federal officials who will be privileged to exploit any and all of us; therefore be it

RESOLVED, that we will not practice compulsory state medicine, which is morally wrong, even on a part time basis, regardless of the insistence of the administration that their program is not compulsory; and be it

RESOLVED, that we will care for our patients under the same freedoms to which we and they have subscribed since the founding of our nation; and that we will care for any and all patients upon terms to be freely and honestly arrived at between patient and physician, and be it further

RESOLVED, that the Medical Association of Georgia House of Delegates instruct its Delegates to the AMA to introduce a similar resolution into the AMA House of Delegates meeting in New York City in June, 1965, so this Association may join with us in this moral move to prevent the eventual advent of total state medicine.

**REFERENCE COMMITTEE RECOMMENDATION**—The Reference Committee approves Resolution No. 7—Compulsory State Medicine with commendation unanimously. This is a moral guidepost. It is recommended that an explanation should be made through the Medical Association of Georgia's Executive Committee of Council to the local medical societies with emphasis on the point that this must be an individual decision.

**HOUSE OF DELEGATES ACTION**—Speaker Walker recognized Linton Bishop, Atlanta, and on motion (Bishop-Eberhart), Dr. Bishop moved as follows: Realizing that this body of physicians is too small to make such an important decision as non-compliance, we hereby resolve that Dr. Eberhart's resolution (Resolution No. 7—Compulsory State Medicine) be mailed to every doctor in the state of Georgia and that the vote be made by mail ballot.

Speaker Walker heard discussion on this motion and after the discussion, Speaker Walker recognized Linton Bishop, Atlanta, who then withdrew the above Bishop-Eberhart motion.

Speaker Walker then recognized Linton Bishop, who moved (Bishop-Logan) to disapprove Resolution No. 7—Compulsory State Medicine. Speaker Walker ruled the Bishop-Logan motion out-of-order, stating that a vote on the Reference Committee Recommendation, which was the previous motion, would resolve the question proposed in the Bishop motion.

At this point, Speaker Walker recognized William Dowda, Atlanta, who moved (Dowda-VanSant) to table the recommendation



of the Reference Committee on Resolution No. 7. Speaker Walker then called for a vote, and the Dowda-VanSant motion to table the Resolution was defeated.

Speaker Walker then called for a vote on the Reference Committee Recommendation, which was in favor of adoption of Resolution No. 7—Compulsory State Medicine. The House then voted to disapprove the Reference Committee Recommendation in favor of Resolution No. 7, and thereby Resolution No. 7 was disapproved.

### Resolution No. 8

#### PREMARITAL EXAMINATION

MURPHY K. CURETON  
WALKER-CATOOSA-DADE COUNTY  
MEDICAL SOCIETY

WHEREAS, present statutes establish a serological test for syphilis as an essential element in applications for a marriage license and,

WHEREAS, such premarital blood tests are essentially of no value in controlling that disease, and

WHEREAS, the Georgia Department of Public Health has recommended the discontinuance of the premarital blood test, and

WHEREAS, the establishment by statute of the details of content of a proper physical examination is an usurpation of the clinical judgment of the physician charged with the responsibility of conducting premarital examinations and

NOW BE IT RESOLVED that the Medical Association of Georgia recommends to the General Assembly that laws relating to marriage be amended to provide for elimination of premarital examinations, including the serological test for syphilis, and

BE IT FURTHER RESOLVED, that such amendment provide for a mandatory waiting period of three days for all marriages without regard for the age

of the individuals and without regard for physical condition including pregnancy.

**REFERENCE COMMITTEE RECOMMENDATION**—The Committee disapproves this resolution and recommends the following rewrite in its place:

"WHEREAS, the venereal rate has been increasing, especially among teenage persons, and

"WHEREAS, some cases of the disease have been detected by serological tests, and

"WHEREAS, a three day waiting period is not supported by medical considerations, and

NOW BE IT RESOLVED, that the Medical Association of Georgia recommends to the General Assembly that laws relating to marriage be amended to provide for a mandatory three day waiting period for marriage for all persons without regard to age or physical condition including pregnancy."

**HOUSE OF DELEGATES ACTION**—Adopted the Reference Committee amendment in lieu of Resolution No. 8—Premarital Examination.

In adopting the Reference Committee amendment to Resolution No. 8—Premarital Examination, the House in effect disapproved Resolution No. 8, and in its place adopted the Resolution proposed by the Reference Committee on this subject of Premarital Examination.

It was moved by Reference Committee No. 5 Chairman W. W. Osborne, Savannah, that the report of Reference Committee No. 5 as amended be approved, and it was so ordered.

Speaker Walker then called for unfinished business, and there being none, Dr. Walker opened the floor for new business. There being no new business, Speaker Walker thanked each and every member of the Reference Committees for their diligent work and entertained a motion for adjournment of the Second Session of the Medical Association of Georgia House of Delegates in conjunction with the 111th Annual Session of the Association. On motion duly made and seconded, the House adjourned at 5:00 p.m.

## MAG GENERAL BUSINESS SESSION (First Session)

111th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

SUNDAY, MAY 2, 1965

THE FIRST GENERAL BUSINESS SESSION of the 111th Annual Session of the Medical Association of Georgia was called to order by President J. G. McDaniel, Atlanta, at 4:35 p.m., in the Embassy Room, Augusta Town House Motor Hotel, Augusta, Georgia, on May 2, 1965.

Dr. McDaniel stated that the purpose of this opening General Business Session was to nominate MAG Officers, Councilors and Vice Councilors, AMA Delegates, and AMA Alternate Delegates, and also to receive nominations for the MAG "General Practitioner of the Year Award."

President McDaniel then called on Dr. Augustin

S. Carswell of Augusta, who delivered the invocation.

At this time, President McDaniel then appointed the MAG Tellers Committee to take charge of the official MAG Ballot Box as follows: Dr. Thomas Goodwin, Augusta, Chairman; Dr. Frank Wilson, Leslie; and Dr. Emory Bohler, Brooklet. Dr. McDaniel announced that the hours for balloting on the nominations made at this session were as follows: May 2—5:30 p.m. to 6:30 p.m.; May 3—9:00 a.m. to 5:00 p.m.; and May 4—9:00 a.m. to 1:00 p.m.; at which time the ballot box would be closed and the votes tabulated by the Tellers Committee with election results to be announced at the final Business Session, Tuesday afternoon, May 4.



## Nominations

President McDaniel then called for nominations from the floor for the Association's Officers and the following nominations were made:

*President Elect*—Walter Brown, Savannah; nominated by J. Kirk Train, Savannah; seconded by W. W. Osborne, Savannah.

There being no other nominations for the office of President-Elect, it was duly moved and seconded that the nominations be closed, and President McDaniel instructed the Secretary to cast a unanimous ballot for Walter Brown as President-Elect of the Medical Association of Georgia.

*Second Vice President*—Lamar Peacock, Atlanta; nominated by Linton Bishop, Atlanta; seconded by Louis Battey, Augusta.

There being no other nominations for the office of Second Vice President, on motion duly made and seconded the nominations were closed and President McDaniel instructed the Secretary to cast a unanimous ballot for Lamar Peacock as Second Vice President of the Medical Association.

President McDaniel then referred to Chapter V, Section 2 of the MAG Constitution and By-Laws as follows: "Nominations for Councilor or Vice Councilor shall be made by each district society at its annual meeting and forwarded by its secretary to the secretary of MAG not later than 15 days before the Annual Session. If no nomination is presented by a district society, nominations shall be made from the floor . . . nominations from county medical societies are handled in like manner."

President McDaniel stated that he had properly received the following nominations from the district and county societies in advance of this meeting and that no nominations from the floor would be in order for the following offices:

*Fifth District Councilor* (1968)—Floyd Sanders, Decatur  
*Fifth District Vice Councilor* (1968)—M. Freeman Simons, Decatur

*Sixth District Councilor* (1968)—William Rawlings, Sandersville

*Sixth District Vice Councilor* (1968)—John A. Bell, Jr., Dublin

*Seventh District Councilor* (1968) — Ralph Johnson, Rome

*Seventh District Vice Councilor* (1968)—W. C. Mitchell, Smyrna

*Eighth District Councilor* (1968)—F. G. Eldridge, Valdosta

*Eighth District Vice Councilor* (1968)—J. W. Yeomans, Jesup

*Muscogee County Medical Society Councilor* (1968)—Luther Wolff, Columbus

*Muscogee County Medical Society Vice Councilor* (1968)—Roy L. Gibson, Columbus

*New Fulton County Medical Society Councilor* (1968)—Linton Bishop, Atlanta

*New Fulton County Medical Society Vice Councilor* (1968)—J. Harold Harrison, Atlanta

*Fulton County Medical Society Vice Councilor* (1966)—Fleming Jolley, Atlanta—to replace former Vice Councilor Linton Bishop who resigned.

*Georgia Medical Society Councilor* (1967)—T. A. Peterson, Savannah—to replace former Councilor Walter Brown who resigned.

*Georgia Medical Society Vice Councilor* (1967)—J. Kirk Train, Savannah—to replace former Vice Councilor T. A. Peterson who resigned.

President McDaniel stated that the names of these nominees as received in proper order according to the MAG Constitution and By-Laws have been printed on the ballot, and that at the close of the election, such nominees would stand elected by the membership.

President McDaniel informed the membership that as of January 1, 1965, the Medical Association of Georgia rated a new Delegate and Alternate Delegate to the American Medical Association because of an increase in MAG membership over the 3,000 mark. He then entertained nominations for the office of new AMA Delegate and Alternate Delegate to serve for a term of two years, beginning January 1, 1965.

*AMA Delegate* (Term beginning January 1, 1965)—Thomas Anderson, Atlanta; nominated by William Dowda, Atlanta; and seconded by John Godwin, Atlanta.

George Dillinger, Thomasville; nominated by W. Frank McKemie, Albany; and seconded by Luther Wolff, Columbus, and Braswell Collins, Macon.

Preston Ellington, Augusta; nominated by Thomas Goodwin, Augusta; and seconded by Addison Simpson, Washington, and Walter Sheppard, Augusta.

There being no further nominations on motion duly made and seconded, it was voted to close the nominations for new AMA Delegate.

President McDaniel called for nominations for new AMA Alternate Delegate.

*New AMA Alternate Delegate* (Term beginning January 1, 1965)—John T. Mauldin, Atlanta; nominated by Milford Hatcher, Macon; and seconded by Charles Andrews, Canton, and Charles Eberhart, Atlanta.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations and President McDaniel instructed the Secretary to cast a unanimous ballot for the election of John T. Mauldin, Atlanta, as new AMA Alternate Delegate.

President McDaniel called for nominations for AMA Delegate (Term beginning January 1, 1966) for the office now held by Dr. J. W. Chambers of LaGrange.

*AMA Delegate* (Term beginning January 1, 1966)—J. W. Chambers, LaGrange, nominated by Charles T. Cowart, LaGrange; and seconded by Roy Gibson, Columbus.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations, and President McDaniel instructed the Secretary to cast a unanimous ballot for the election of J. W. Chambers as AMA Delegate.

President McDaniel called for nominations to the office of AMA Alternate Delegate, stating that



he had received in proper form the resignation of the incumbent Alternate Delegate George Dillinger, whose term would expire at the close of this year. Dr. Dillinger served as Alternate Delegate to Dr. J. W. Chambers. Therefore, Dr. McDaniel suggested that the nomination at this time should not only pertain to a candidate who would take office January 1, 1966, but who would also fill the unexpired term of office of Dr. Dillinger for the remainder of this year, due to his resignation. Dr. McDaniel, hearing no disapproval of this suggestion, then proceeded to call nominations for Alternate Delegate to AMA to fill both the unexpired term of the incumbent and in addition to serve a new term beginning January 1, 1966.

*AMA Alternate Delegate* (Unexpired term beginning May 2, 1965, and regular term beginning January 1, 1966)—T. A. Sappington, Thomaston; nominated by Norman Gardner, Thomaston; and seconded by Robert Huie, Decatur.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations and President McDaniel instructed the Secretary to cast the unanimous ballot for the election of T. A. Sappington, as AMA Alternate Delegate for both the unexpired term of George Dillinger, and a new term of office beginning January 1, 1966.

President McDaniel called for nominations for the office of AMA Alternate Delegate now held by Thomas Goodwin of Augusta, whose term of office runs until December 31, 1966, but who has submitted his resignation. It was noted that Dr. Goodwin has served as Alternate Delegate to Delegate J. Frank Walker.

*AMA Alternate Delegate* Unexpired term beginning May 2, 1965, ending December 31, 1966)—John Kirk Train, Savannah; nominated by Robert Gottschalk, Savannah; and seconded by A. F. Williams, Savannah.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations and President McDaniel instructed the

Secretary to cast the unanimous ballot for the election of J. Kirk Train as AMA Alternate Delegate to fill the unexpired term of Thomas Goodwin.

Dr. McDaniel announced that he had received the resignation in proper form of AMA Alternate Delegate Preston Ellington, whose term of office was to run until December 31, 1966. It was noted that Dr. Ellington has served as Alternate Delegate to Henry Tift.

*AMA Alternate Delegate* (Unexpired term beginning May 2, 1965, ending December 31, 1966)—John S. Atwater, Atlanta; nominated by Albert Rayle, Atlanta; and seconded by Walker Curtis, Atlanta.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations and President McDaniel instructed the Secretary to cast the unanimous ballot for the election of John S. Atwater as AMA Delegate, term beginning May 2, 1965, and expiring December 31, 1966.

### G.P. of the Year Award

As the last order of business of this first Business Session, President McDaniel then called for nominations for the Medical Association of Georgia's "General Practitioner of the Year Award." The following nominations were made:

Robert G. Stephens, Washington; nominated by the Wilkes County Medical Society.

Charles H. Dickens, Madison; nominated by the Oconee Valley Medical Society.

Dr. McDaniel announced that these nominations were officially received and that the House of Delegates would select from these two nominations the 1965 recipient of the "General Practitioner of the Year Award," which would be presented at the final Business Session, May 4.

There being no further business, the First General Business Session of the 111th Annual Session of the Medical Association of Georgia was recessed at 5:30 p.m.

## MAG GENERAL BUSINESS SESSION (Second Session)

111TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

MONDAY, MAY 3, 1965

THE SECOND GENERAL BUSINESS SESSION of the 111th Annual Session of the Medical Association of Georgia was called to order by President J. G. McDaniel, Atlanta, at 9:05 a.m., in the Embassy Room, Augusta Town House Motor Hotel,

Augusta, Georgia, on May 3, 1965.

The invocation was given by the Rev. Allen B. Clarkson, Rector of the Good Shepherd Episcopal Church of Augusta, Georgia.

A word of welcome was given by Dr. Cecil A.



White of Augusta, as President of the Richmond County Medical Society, in behalf of the membership of the society as hosts for this 111th Annual Session.

President McDaniel then introduced the Honorable George A. Sanchen, Jr., Mayor of the City of Augusta, who welcomed the membership of the Medical Association of Georgia to the fair City of Augusta on this occasion of the Association's Annual meeting.

President McDaniel then introduced President-Elect George Alexander of Forsyth, who presented an address to the Association's membership on the Association's future activities for the year 1965-66.

**MAG Memorial Service**

Dr. J. G. McDaniel, as Association President, then closed the Second Business Session on a solemn note with the convening of the annual MAG Memorial Service. President McDaniel led the membership in repeating the 23rd Psalm in memory of those Medical Association of Georgia members deceased during the past year. Following this prayer, Dr. McDaniel read the names of these departed colleagues.

- Thomas Arthur Amburgey, Savannah, October 10, 1964
- M. W. Anderson, Social Circle, February 2, 1965
- M. K. Bailey, Atlanta, June 21, 1964
- W. G. Banister, Rome, January 13, 1965
- L. Minor Blackford, Atlanta, May 5, 1964
- Montague Lafayette Boyd, Atlanta, January 9, 1965

- James M. Burdine, Atlanta, November 4, 1964
- Sylvester Cain, Norcross, February 28, 1965
- Arthur William DeLoach, Waycross, October 24, 1964
- Murdock Sykes Equen, Atlanta, November 11, 1964
- William H. Good, Toccoa, June 30, 1964
- William H. Hadaway, LaGrange, July 26, 1964
- D. L. Head, Sr., Zebulon, February 3, 1965
- William A. Hodges, Sr., Lakeland, Florida, March 18, 1965
- George H. Holsenbeck, Atlanta, February 23, 1965
- W. A. Jennings, Augusta, October 26, 1964
- Horace Greeley Joiner, Douglas, April 30, 1964
- H. H. Lancaster, Shady Dale, April 2, 1965
- Martin L. Malloy, Vienna, August 23, 1964
- W. F. Massey, Chester, July 15, 1964
- Robert Ellis May, Lincolnton, August 23, 1964
- Paul McDonald, Bolton, July 23, 1964
- Joseph B. Mercer, Brunswick, December 12, 1964
- Clarence W. Mills, Jr., Atlanta, November 16, 1964
- J. L. Morris, Alpharetta, February 14, 1964
- Charles M. Mulherin, Augusta, May 14, 1964
- Phillip A. Mulherin, Augusta, December 1, 1964
- Elizabeth Peabody, Atlanta, February 18, 1965
- John H. Pinholster, Savannah, August 9, 1964
- John Ernest Powell, Sr., Villa Rica, September 8, 1964
- Earl Rasmussen, Atlanta, June 24, 1964
- Helen Sharpley, Savannah, February 19, 1964
- J. O. Simmons, Woodbine, January 6, 1965
- Donald W. Singleton, Atlanta, November 14, 1964
- George W. Smith, Augusta, April 18, 1964
- J. R. Smith, Hahira, December 5, 1964
- Phillip P. Sydenstricker, Augusta, December 12, 1964
- W. H. Tanner, Newnan, December 8, 1964
- E. M. Townsend, Ringgold, February 19, 1965
- J. P. Tye, Albany, March 25, 1965
- J. C. Verner, Commerce, June 29, 1964
- O. A. Woods, Washington, May 23, 1964

There being no further business, President McDaniel adjourned this Second MAG Business Session at 9:35 a.m.

**MAG GENERAL BUSINESS SESSION (Third Session)**  
**111TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA**  
**TUESDAY, MAY 4, 1965**

THE THIRD GENERAL BUSINESS SESSION of the 111th Annual Session of the Medical Association of Georgia was called to order by President J. G. McDaniel, Atlanta, at 5:00 p.m., in the Embassy Room, Augusta Town House Motor Hotel, Augusta, Georgia, on May 4, 1965.

**Fifty-Year Certificates**

President McDaniel called on Chairman of MAG Council, Addison Simpson, Jr., of Washington, Georgia, to present the Fifty-Year Certificates and Pins to physician members who have practiced medicine for 50 years or more. These presentations were made to the following physicians:

- Wayne Aiken, Atlanta; James F. Arthur, Atlanta; Robert M. Avery, LaGrange; Horace E. Crow, Oakwood; Crawford

- W. Dyer, Macon; David H. Garrison, Clarkesville; Walton A. Johnson, Elberton; Marcus Mashburn, Cumming; William W. Meriwether, Macon; H. E. Nash, Sr., Atlanta; William A. Newman, Macon; William Parks Phillips, LaGrange; William T. Randolph, Winder; Eugene F. Thompson, Valdosta; John William Turner, Atlanta; Lloyd L. Whitley, Athens; Solomon S. Youmans, Swainsboro.

**Scientific Exhibits Awards**

President McDaniel called on John McClure of Atlanta, Chairman of the Association's Scientific Exhibit Awards Committee, who made the following presentations:

- First Place Award—"Pseudomonas Sepsis of Burns"  
H. Harlan Stone, M.D., and J. D. Martin, Jr., M.D., Atlanta
- Second Place Award—"Gametogenesis: Stimulation of Ovulation and Spermatogenesis"  
Robert B. Greenblatt, M.D.; Somnath Roy, M.D.;

Virendra B. Mahesh, Ph.D.; Edwin C. Jungck, M.D., Augusta.

**Third Place Award—"The Membrane Lung"**

E. Converse Peirce, II, M.D., and Pierre M. Galletti, M.D., Atlanta.

**GP of the Year Award**

President McDaniel called on Dr. Hubert Milford of Hartwell, Georgia, President of the Georgia Academy of General Practice, to present the "GP of the Year Award." Dr. Milford presented this high award to Dr. Robert G. Stephens of Washington, Georgia.

**Certificates of Appreciation**

President McDaniel called on the Association's Secretary John T. Mauldin of Atlanta, to present the Certificates of Appreciation to persons recognized by the Association for their activity in behalf of the Medical Association of Georgia. Dr. Mauldin presented these Certificates as follows:

Dr. J. G. McDaniel, Atlanta, for service as MAG President; Mrs. John Leslie, Decatur, for service as Woman's Auxiliary to the MAG President; Dr. John Kirk Train, Savannah, for service as First Vice President; Dr. Harry Pinson, Augusta, for service as Chairman of the Association's Relative Value Study Committee; Dr. Linton Bishop, Atlanta, for service as Chairman of the MAG Public Relations Board; Dr. W. D. Stripling, Gainesville, for service as Chairman of the MAG Mental Health Subcommittee; Dr. Charles T. Cowart, LaGrange, for service as Chairman of the Georgia Hospital-Medical Council; Dr. J. Rhodes Haverty, Atlanta, for service as Chairman of the MAG Weekly Health Column Subcommittee; Dr. Addison W. Simpson, Washington, for service as Chairman of the MAG Council; Mr. Richard Nelson, Chicago, for service as a member of the American Medical Association Field Service Staff; Dr. Eugene L. Griffin, Atlanta, for service as Chairman of the Maternal and Infant Welfare Subcommittee; Dr. Joseph B. Mercer, Brunswick, for service as Vice Speaker of the MAG House of Delegates presented posthumously; and Dr. J. Frank Walker, Atlanta, for service to the Association in the field of legislative affairs.

**Hardman Award**

President McDaniel called on President-Elect George Alexander to make the presentation of the Hardman Award. This award is given for the achievement of anyone, who in the judgment of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery or such contribution to the science of medicine.

President-Elect George Alexander then presented this high honor and award to J. H. Kite of Atlanta.

**Distinguished Service Award**

President McDaniel presented the Association's Distinguished Service Award, which is given for distinguished and meritorious service which reflects credit and honor to the Association. Dr. McDaniel presented this award to Dr. Milford Hatcher of Macon.

**Special Presentation**

President McDaniel called on J. Kirk Train, First Vice President from Savannah, and Robert Gottschalk, Savannah, President of the Georgia Medical Society. Dr. McDaniel presented a picture of John Wesley, one of the first medical missionaries in America, to these representatives of the Georgia Medical Society in behalf of the AMA Publication, *Today's Health*. This original art work was used in a story published in *Today's Health* describing the medical missionary activities of John Wesley when he was in Savannah, Georgia, and Fredricka.

**Site of 1967 Annual Session**

President McDaniel announced that the site for the 1966 Annual Session had been previously set for Columbus, Georgia, on invitation of the Muscogee Medical Society. Dr. McDaniel then called for invitations to MAG to convene the 1967 Annual Session.

Lamar Peacock, President of the Fulton County Medical Society, was recognized and rendered an invitation to the Association to hold its 1967 Annual Session in Atlanta, the Capitol City of the State of Georgia, and the invitation was graciously accepted. The Association will then convene its 1967 Annual Session in Atlanta, Georgia.

**Election Results**

President McDaniel called on the Chairman of the Tellers Committee, Thomas Goodwin, who announced that in the single contested race, Preston Ellington of Augusta had been elected by majority vote as the MAG New Delegate to the American Medical Association.

**Official Attendance Records**

President McDaniel announced that the official attendance at the 111th Annual Session of the Medical Association of Georgia held in the Augusta Town House Motor Hotel, May 2-4, was as follows:

MAG members—622; Other Physicians—79; Guests—74; and Exhibitors—105; thereby making a grand total of 880 registered.

**Installation of Officers**

The next order of business was the installation of 1965-66 Officers and Councilors as follows:

*President*—George Alexander, Forsyth (1966)  
*President-Elect*—Walter E. Brown, Savannah (1966)  
*Immediate Past President*—J. G. McDaniel, Atlanta (1966)  
*First Vice President*—Henry S. Jennings, Jr., Gainesville (1966)  
*Second Vice President*—Lamar B. Peacock, Atlanta (1966)  
*Speaker of the House*—J. Frank Walker, Atlanta (1968)  
*Vice Speaker of the House*—Harrison L. Rogers, Jr., Atlanta (1968)



*Fifth District Councilor*—Floyd Sanders, Decatur (1968)  
*Fifth District Vice Councilor*—M. F. Simmons, Decatur (1968)  
*Sixth District Councilor*—William Rawlings, Sandersville (1968)  
*Sixth District Vice Councilor*—John Bell, Dublin (1968)  
*Seventh District Councilor*—Ralph N. Johnson, Rome (1968)  
*Seventh District Vice Councilor*—W. C. Mitchell, Smyrna (1968)  
*Eighth District Councilor*—F. G. Eldridge, Valdosta (1968)  
*Eighth District Vice Councilor*—J. W. Yeomans, Jesup (1968)  
*Georgia Medical Society Councilor*—T. A. Peterson, Savannah (1967)  
*Georgia Medical Society Vice Councilor*—John Kirk Train, Savannah (1967)  
*Muscogee County Medical Society Councilor*—Luther H. Wolff, Columbus (1968)  
*Muscogee County Medical Society Vice Councilor*—Roy L. Gibson, Columbus (1968)  
*Fulton County Medical Society Councilor*—Linton H. Bishop, Atlanta (1968)  
*Fulton County Medical Society Vice Councilor*—J. Harold Harrison, Atlanta (1968)  
*Fulton County Medical Society Vice Councilor*—Fleming L. Jolley, Atlanta (1966)  
*AMA Delegate*—Preston D. Ellington, Augusta (12-31-66)

*AMA Alternate Delegate*—John T. Mauldin, Atlanta (12-31-66)  
*AMA Delegate*—J. W. Chambers, LaGrange (12-31-67)  
*AMA Alternate Delegate*—T. A. Sappington, Thomaston (12-31-67)  
*AMA Alternate Delegate*—John S. Atwater, Atlanta (12-31-66)  
*AMA Alternate Delegate*—John Kirk Train, Savannah (12-31-66)

Immediate Past President, J. G. McDaniel, then turned the gavel of leadership of the profession in Georgia over to incoming President George Alexander.

At this time President Alexander presented Immediate Past President, J. G. McDaniel, with a token of the Association's appreciation for Dr. McDaniel's service as MAG President during the past year. Dr. Alexander gave Dr. McDaniel a bound copy of the *Journal of the Medical Association of Georgia*, published during the term of office of former President McDaniel.

There being no further business, President Alexander adjourned the 111th Annual Business Session of the Association at 5:35 p.m.

# NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

Ammons, John C. DE-2—Fulton	80 Butler St., S.E., P.O. Box 26036, Atlanta, Ga., 30303	McCracken, William C. Active—Cherokee-Pickens	Woodstock Medical Center Woodstock, Georgia
Anderson, John L., Jr. Active—Southeast Georgia	Georgia State Prison Reidsville, Georgia	McCranie, Martha S. Active—Richmond	Talmadge Memorial Hospital Augusta, Georgia
Bowers, Robert E. Active—Whitfield	Burleyson Drive Dalton, Georgia	Mitchener, J. W. Active—Richmond	University Hospital Augusta, Georgia
Chavez, Marcelino I. Active—Richmond	Talmadge Memorial Hospital Augusta, Georgia	Mahan, D. R., Jr. Active—Whitfield	Memorial Drive Dalton, Georgia
Crews, Thomas L. Active—Newton-Rockdale	310 N. Mill Street Conyers, Georgia	Osborne, Horace H. Active—Crawford W. Long	St. Mary's Hospital Athens, Georgia
Daily, F. Willson—Active Georgia Medical Society	11-A Medical Arts Center Savannah, Georgia	Pool, Winford H., Jr. Active—Richmond	Talmadge Memorial Hospital Augusta, Georgia
Davis, Robert S. Active—Fulton	U.S. Army Hospital Ft. McPherson, Georgia	Rainey, Robert L. Active—Richmond	Medical College of Georgia Augusta, Georgia
Davis, William S. Active—Floyd	Harbin Clinic Rome, Georgia	Robinson, Harold G. Active—Floyd	14 Hospital Rome, Georgia
DeVore, Margaret B. Active—Richmond	Medical College of Georgia Augusta, Georgia	Strickland, Edmond T., Jr. DE 2—Bibb	Macon Hospital Macon, Georgia
Edmondson, H. T., Jr. Active—Richmond	V. A. Hospital Augusta, Georgia	Tanner, Robert E. Active—Richmond	1427 Harper Street Augusta, Georgia
Hand, Robert A. Active—Richmond	St. Joseph Hospital Augusta, Georgia	Weaver, William T. Active—Fulton	401 Peachtree Street, N.E. Atlanta, Georgia 30309
Howard, James W. Active—Fulton	3433 Lynfield Drive, S.W. Atlanta, Georgia 30311	Whitner, Elizabeth S. Active—Floyd	Ga. Sch. for the Deaf Cave Spring, Georgia
Lindsay, H. H. Active—South Georgia	411¼ S. Ashley St. Valdosta, Georgia	Wood, Marcella D. DE 3—Fulton	3764 Briarcliff Road, N.E. Atlanta, Georgia





J. Frank Walker, Atlanta, Speaker of the MAG House of Delegates.



Left to Right—Congressman Robert G. Stephens, Jr., Washington, D.C.; MAG Past President, J. G. McDaniel, Atlanta; General Practitioner of the Year, Robert G. Stephens, Sr., Washington, Georgia; GAGP President, J. Hubert Milford, Hartwell, Georgia.



Left to Right—A. Calhoun Witham, Augusta; Thomas Findley, Augusta; William B. Bean, Iowa City, Iowa; J. G. McDaniel, Atlanta; F. Phinzy Calhoun, Jr., Atlanta.



MAG Past President, J. G. McDaniel, Atlanta



Abner W. Calhoun Memorial Lectureship Guest Speaker, William B. Bean, Iowa City, Iowa.



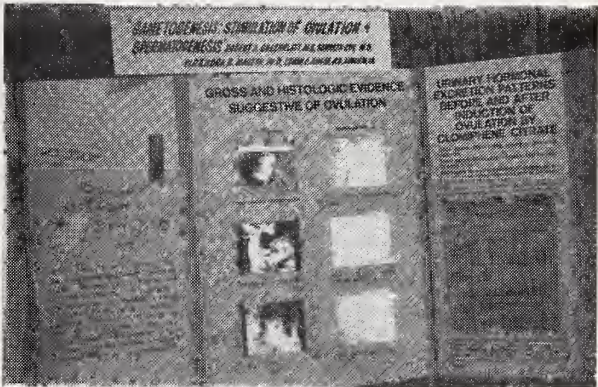
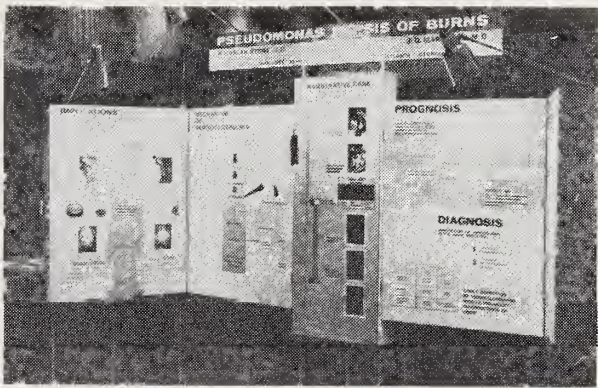
MAG House of Delegates In Action

## 111th ANNUAL SESSION AUGUSTA





Left to Right—Lamar B. Peacock, Atlanta, MAG Second Vice President; Henry S. Jennings, Jr., Gainesville, MAG First Vice President; Edwin C. Evans, Atlanta.



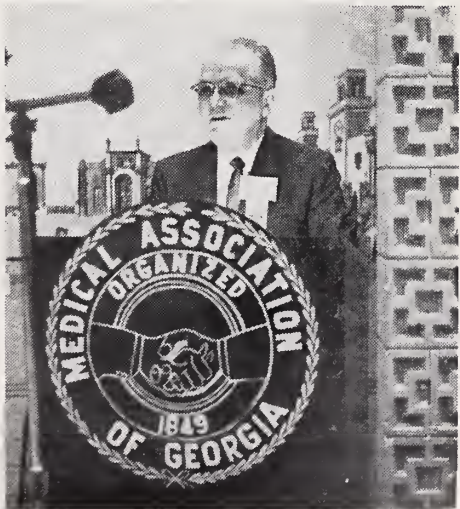
Scientific Exhibits Award Winners—Top to Bottom: First Place, "Pseudomonas Sepsis of Burns;" Second Place, "Gametogenesis: Stimulation of Ovulation & Spermatogenesis;" Third Place, "The Membrane Lung."



Obstetrics & Gynecology, Internal Medicine and General Practice Joint Section Meeting Guest Speakers. Left to Right—Priscilla White, Boston; Michael Newton, Jackson, Mississippi; Frank A. Finnerty, Jr., Washington, D.C.; and Edward J. Dennis, Charleston, S.C.



Reference Committee No. 2; Robert E. Wells, Atlanta, Speaking.



MAG President, George H. Alexander, Forsyth





## Savannahian, Walter E. Brown, Chosen New MAG President-Elect



**A** FOURTH GENERATION Georgia physician, Walter E. Brown of Savannah, was chosen as the 1965-66 Medical Association of Georgia President-Elect at the 111th Annual Session held May 2-4, 1965, at Augusta, Georgia.

Dr. Brown, who feels that cooperation with ancillary medical organizations—hospitals, boards of health, nurses, etc., should be emphasized as one of MAG's most important programs, is a 1931 graduate of the Medical College of Georgia, Augusta. He served his internship at Piedmont Hospital, Atlanta, and his residency at Central of Georgia Hospital, Savannah.

Dr. Brown has been in private practice as a general practitioner and surgeon in Savannah since 1931. His son, who is now in his residency at Macon General Hospital, will be the fifth generation of Brown physicians. To Dr. Brown's knowledge, the Brown family is the only "unbroken" fifth generation succession of doctors in the country. His father, grandfather and great-grandfather all practiced in Sharon, Georgia, in Taliaferro County. He is the first of his family to set up practice in Savannah.

### The Doctor In Politics

Queried regarding the doctor's role in politics, Dr. Brown stated that he was definitely in favor of the doctor's playing an ever-widening role in the po-

litical world, not only as supporters of medicine's cause, but as elected participants. There are presently six doctors in the Georgia legislature, more than any other State assembly in the U.S.

As a general practitioner, Dr. Brown is particularly interested in an expanded role for the future GP. He stated that not only should the GP's image of themselves be upgraded, but also that the public should be made aware of the GP's important role in the community. The means of encouraging this program are already gaining impetus with the installation of GP residency programs in hospitals throughout the U.S. Macon General Hospital, and Crawford W. Long Memorial Hospital, Atlanta, presently have GP residency programs in Georgia.

### Increased Membership

"Increased membership in MAG and AMA is important," said Dr. Brown, "and this should be emphasized by the local, county medical societies. It is imperative that the advantages and benefits of participation in both organizations be pointed out." He said it is one thing to be a dues paying member, but quite another to be an active participant. Active participation is his aim.

Concerning postgraduate medical education, he feels that the present program is a good one, but that, as in all good things, it, too, can be expanded. He feels that it is important that doctors of all ages—residents through retired physicians—should actively take advantage of the programs now offered.

As President-Elect, it is Dr. Brown's job to learn for a year, and then implement as many of the programs as possible that he will inherit from George H. Alexander, 1965-66 President of the Medical Association of Georgia; plus ideas of his own that he wishes to see fulfilled as the next MAG President.



# Mannitol and Acute Renal Failure

**M**ANNITOL, the reduced form of the 6-carbon sugar, mannose, has been known to renal physiologists for years as an effective and useful osmotic diuretic. It is inert in the body, and after intravenous injection, is largely retained within the vascular compartment. It is, however, filtered readily by the glomerulus. Once it enters the renal tubule it is not reabsorbed. Its osmotic effect reduces proximal reabsorption of water and sodium, resulting in a brisk diuresis. Studies have not revealed any increase in cardiac output or glomerular filtration rate following intravenous infusion of mannitol and the diuretic effect is most likely due entirely to its osmotic effect in the renal tubule.

## Revived Interest

The report of Barry<sup>1</sup> on the use of mannitol to prevent oliguria during aortic surgery revived interest in this substance as a possible means of preventing renal tubular damage following events known to cause acute tubular necrosis. Several subsequent reports indicate that when mannitol is given within a short time after the renal insult, the expected acute renal failure may be averted in many cases. Timing is of great importance, for if too long a period of time has elapsed, no diuresis will result. This time interval appears to be the first 24 to 36 hours.

In experimental studies, Parry and co-workers<sup>2</sup> confirmed the effectiveness of mannitol in preventing acute renal failure in rats challenged with a low-sodium acid-ash diet, dehydration and methemoglobin pigment injection, a method consistently producing renal failure in unprotected animals. Only one of 87 animals died when mannitol was given immediately after methemoglobin. If mannitol injection was delayed 30 minutes, only 27% survived, and after one hour, all died in renal failure. The large, impressive renal casts seen in unprotected

animals were not seen in those receiving mannitol early. This observation leads to the attractive hypothesis that cast formation may be etiologically important in the production of renal ischemia and tubular necrosis, and not a secondary phenomenon, as claimed by those supporting the ischemic theory of Oliver.

It should be emphasized that the osmotic effect of mannitol depends only on the presence of glomerular filtration and is independent of those factors regulating over-all body fluid economy. Dehydration or hypovolemia may be aggravated by mannitol diuresis, and the physician must be alert to correct these deficiencies, when present, by appropriate means, at the same time that mannitol is used to prevent disastrous renal damage.

If mannitol is not excreted, due to the lack of adequate glomerular filtration, it accumulates in the vascular compartment and, by its osmotic effect, acts as a plasma volume expander. Thus, if a diuresis does not ensue, continued administration may precipitate heart failure. Usually a test dose of 12.5 Gms is given, and if no diuresis occurs, further use is contraindicated.

If these precautions are kept in mind, mannitol should prove to be a useful agent in the prevention of acute renal tubular necrosis.

Joseph Wilson, M.D.  
490 Peachtree Street, N.E.  
Atlanta, Georgia 30308

## REFERENCES

1. Barry, K. G.; Cohen, A.; Knochel, J. P.; Whelan, T. J., Jr.; Beisel, W. R.; Vargas, C. A., and LeBlanc, P. C., Jr.: Mannitol Infusion: II. Prevention of Acute Functional Renal Failure during Resection of Aneurysm of the Abdominal Aorta. *New England Journal of Medicine* 264:967-971, May 11, 1961.
2. Parry, W. L.; Schaefer, J. A., and Mueller, C. B.: Experimental Studies of Acute Renal Failure: I. Protective Effect of Mannitol. *J. Urol.* 89:1-6, January 1963.

## 1965 CALENDAR OF MEETINGS

### State

May 1-3, 1966—112th Annual Session of the Medical Association of Georgia, Columbus.

### Regional

June 16-19—Society of Nuclear Medicine, Americana Hotel, Bal Harbour, Fla.

June 28-July 1—American Orthopaedic Association, Hot Springs, Va.

August 19-21—18th Annual Postgraduate Obstetric-Pediatric Seminar sponsored by the Children's Bureau, the Maternal and Child Health Services of Georgia, Alabama, South Carolina, Florida and Mississippi, and Medical Associations of the five states, Ramada Inn, Cocoa Beach, Fla.

August 22-27—11th Annual Flying Physicians Association, Deauville Hotel, Miami Beach, Fla.

September 9-11—American Association of Obstetricians and Gynecologists, Homestead, Hot Springs, Va.

September 14-17—American Association of Blood Banks, Americana Hotel, Bal Harbour, Fla.

September 27-28—Tennessee Valley Medical Assembly, Tivoli Theatre, Chattanooga, Tenn.

### National

June 17-21—31st Annual Meeting of the American College of Chest Physicians, Waldorf-Astoria Hotel, New York City.

June 20-24, 1965—American Medical Association, Americana Hotel, New York City.



## ON FILLING THE SHOES OF A PHILOSOPHER

SOME of you may recall that in my preliminary remarks at Augusta, I commented on the fact that I had followed Dr. McDaniel as Chairman of Council and now find myself as President, again trying to fill his shoes. It is amazing that a man no bigger than "Mac" can wear such big shoes and take such long strides.

### Difficult To Equal

In reviewing the articles on the President's Page for the last year one fact stands out, and that is that "Mac" is quite a philosopher, and in that area it will be difficult to equal him. However, as the year unfolds, I am hopeful of being able to have things to say which will be interesting and helpful concerning the problems which our Association and the profession will have to face and try to solve or live with.

As this is being written, the Senate has not yet begun its consideration of the House passed Health Care bill. I have before me some clippings from the AMA News of April 19, 1965—some of these being quotes taken from the daily press and another being a statement by Dr. Donovan Ward, AMA President. I would like to briefly quote from some of these—out of context.

Russell Kirk in the *Los Angeles Times* said: "The AMA's alternative to Medicare, their 'Eldercare' plan ought to be seriously weighed by the present Congress. Physicians, after all, do know something about the functioning of their own profession."

The *Gastonia, N.C., Gazette*: "The people of Britain have learned to their sadness that there is no such thing as 'free' medical care. Worse still, there is ample evidence that medicine to whatever extent it is controlled by government, will inevitably be reduced in quality by the same extent."

*Lockport, N.Y. Union Sun and Journal*: "As the outlook for increased taxation on every working man and woman becomes clear, Congress may find a widespread cooling off among those who have expected some kind of magic services . . . (Medicare) will be a costly provision. . . . It could be a case of when we get what we want we don't want it."

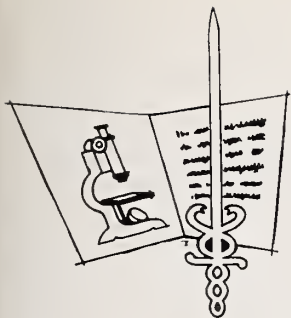
From the foregoing it would appear that many are taking a second look. Let us hope so, and let us also hope that it is *not* too late!!

Now from Dr. Ward: "We hope the Senate will proceed with caution and will conduct full and fair public hearings so that this bill can be thoroughly understood by everyone. We hope that the legislation which finally emerges will be sound and just and will reflect the desires of a majority of the people."

Finally, if we should lose, let us remember our obligation and responsibility as Physicians and Americans to "live with it," but not to give up our right as Americans to fight to make changes where they are found to be desirable or necessary.

George H. Alexander, M.D.  
President, Medical Association of Georgia





## THE AMERICAN CANCER SOCIETY AND THE PHYSICIAN

John P. Wilson, M.D., *Atlanta*

THE AMERICAN CANCER SOCIETY, more so than some other voluntary health agencies, has a particularly close relationship with the medical profession. While it is, in large part, a voluntary lay organization, its direction and function is through the medical profession and it depends on the active participation of doctors in the various facets of its programs to carry out that function. It is well then for the medical profession to be familiar with these programs.

The American Cancer Society is engaged in three programs primarily: 1. Research. 2. Service To Patients. 3. Professional and Public Education. In each one of these there is an effective relationship with the medical profession.

### Research

A portion of the funds of the American Cancer Society are allotted to direct support of research in cancer. There are, of course, several agencies involved in cancer research, including the Federal Government. However, the American Cancer Society supports a significant program of research and allows especially for latitude in areas which are not covered by other agencies. There are a number of research projects in Georgia which are supported by the American Cancer Society.

### Patient Services

Because many of the needs of indigent patients are cared for by state and local programs, such as Cancer State Aid, the direct care of cancer patients is not a major portion of the American Cancer Society's program. It would financially be impossible for the Cancer Society to underwrite the care of any significant number of cancer patients. However, there are many areas in the direct care of patients in which the Cancer Society is active.

1. *Dressings and Loan Closets.* Many of the units

of the American Cancer Society, particularly in the larger cities, have loan closets to provide beds, wheel chairs, crutches and sick room conveniences. Dressings are also prepared by volunteers and are available without cost to cancer patients.

2. *Transportation* may be provided for indigent patients to and from Cancer Clinics by volunteer workers, and in particular cases, by financial arrangements where other means of transportation are not available.

3. *Pain Relieving Drugs.* A limited allotment per month for advanced and terminal cancer patients is available for indigent patients.

4. *Information Center.* In some units of the Cancer Society, as in the Fulton County Unit, there is an Information Center to help indigent cancer patients contact and make arrangements with the appropriate agency for their needs. Contacts with Laryngectomy and Ileostomy Clubs can be arranged for rehabilitation of postoperative patients.

5. *Support of Institutions for terminal patients.* In the Atlanta area the Cancer Society contributes to the support of the Home of Our Lady of Perpetual Aid.

### Professional and Public Education

The major activity of the American Cancer Society is the area of Professional and Public Education. While other agencies are involved in patient care and research, the American Cancer Society is the only agency which is engaged in public education regarding early diagnosis and treatment of cancer, which is, of course, basic in cancer control today.

1. Professional education includes an attempt to help physicians keep abreast of current information regarding cancer through the publication *Ca*, special bulletins and sponsorship of seminars and speakers at medical meetings. Professional films are also available for programs and meetings. Speakers can be provided for county society meetings.

2. The public education program of the American Cancer Society is designed to enlighten the public on the importance of early diagnosis and treatment for successful cancer control, through meetings, film showings, radio, newspaper and TV programs and special public educational publicity programs, such as the recent Pap smear program in Fulton County. An abundance of literature and a number of excellent films are available without cost.

Stress has been placed on the importance of early diagnosis by the seven danger signals and by advising Annual Health Examinations, including Pap smear and proctosigmoidoscopic examination. The importance of the prevention of cancer has been stressed in the antismoking campaign among teenagers.

#### **How Effective**

How effective is the public education program and are doctors taking advantage of this program? In some areas there has apparently been good response. The effectiveness of the Pap smear has been apparent and it is the rare physician today who does not utilize

this extremely effective diagnostic tool. On the other hand, routine proctosigmoidoscopic examination has not met with ready acceptance. Some reasons are obvious. It is more difficult, time consuming, requires preparation and is more uncomfortable than the Pap smear, and yet 75% of all cancer of the colon and rectum, the most common of all cancers, are located within reach of the sigmoidoscope. There is no question that statistically there is a greater yield of treatable neoplasms as a result of routine proctosigmoidoscopic examination than with routine chest x-ray.

It is important that the physician familiarize himself with the Cancer Society's program and to provide the patient with the basic cancer detection methods available, including the Annual Health Examination, Pap smear, proctosigmoidoscopic examination, instruction on breast self-examination, chest x-ray and other examinations as indicated. It is an uncomfortable question to have a layman ask occasionally, "What do I do when my doctor won't do a proctosigmoidoscopic examination or a Pap smear?"

The Cancer Society has a real service to offer the physician who will take advantage of it.

*304 Boulevard, N.E.*

---

*Approved by the Professional Education Committee, Georgia Division, ACS.*

## **'MEDICAL ECONOMICS' TO OFFER CARIBBEAN CRUISE FOR BEST ORIGINAL ARTICLE BY PHYSICIAN**

A 10-day expenses-paid Caribbean vacation for two awaits the doctor who wins the top 1965 MEDICAL ECONOMICS Award for "the best original article by a physician." Two runners-up will receive cash Awards of \$500 each.

#### **First Year For Top Award**

Originated in 1956, the magazine's annual Awards competition encourages physicians to share professional and personal experiences with their colleagues. This is the first year that a top Award other than cash has been offered to supplement regular payment for accepted manuscripts.

The winner can take the winter holiday at any time between next December 1 and March 31, 1966. It includes round-trip air transportation for two to Jamaica, B.W.I., a stay at the luxurious Half Moon Hotel, and such no-cost "extras" as a guided tour of Montego Bay and a flight to Port Antonio followed by a day's rafting down the Rio Grande.

#### **Deadline**

August 31 is the deadline for submissions. Manuscripts, or requests for more information, should be mailed to: Awards Editor, MEDICAL ECONOMICS, Oradell, N.J. 07649.





## ARTIFICIAL CARDIAC PACEMAKERS

Paul H. Robinson, M.D.

Edward R. Dorney, M.D., *Atlanta*

**T**HE PHARMACOLOGICAL treatment of complete heart block with Stokes-Adams attacks has never been entirely satisfactory. The clinical application of electronic pacemakers, either a temporary cardiac catheter electrode or the permanently implanted internal variety, has been a great advance in the management of this problem. However, as is so frequent with new techniques, it has been fraught with perplexities, technical problems and complications.

### Construction

The bipolar pacemaker catheter consists of two insulated wires within a cardiac catheter terminating at electrode rings near the catheter tip. For greater stability and to allow the patient free arm motion, the catheter is usually placed in the right or left external jugular vein and advanced, under fluoroscopic control, to rest in the outflow tract of the right ventricle. The antecubital vein may be used as an alternate site for catheter insertion. The wires are then connected to an external battery source whose voltages and impulse rate may be controlled. Approximately 1.5 to 5.0 volts are normally required for pacing. The impulse rate is determined by the clinical situation but is usually set at 75-80 beats per minute. Indications for a catheter pacemaker are:

1. Treatment of Stokes-Adams attacks interrupting complete heart block or sinus rhythm prior to placement of a permanent pacemaker.
2. During surgery for placement of a permanent pacemaker.
3. Acute myocardial infarction with complete heart block.
4. Ineffective ventricular rate during second or third degree heart block.
5. During surgery in a patient with complete heart block and without Stokes-Adams attacks to assure cardiac function.

Thrombophlebitis is rarely seen with this temporary type of therapy. Emboli have not been experienced, and anticoagulants are not required. Intermittent failure of pacing because of shift in position of the catheter can be remedied by moving the catheter tip. Ventricular arrhythmias, including fibrillation, are a potential hazard due to improper grounding of equipment, and it is suggested that a battery source of current should be used.

During certain open-heart procedures, complete heart block may be produced. Constant cardiac monitoring helps to avoid this complication. How-

ever, manipulation and trauma about the AV node and common bundle may produce sufficient edema and injury to induce block. If such occurs while the chest is still open, a removable myocardial wire is placed through the anterior surface of the right ventricle away from the coronary vessels and brought out through the chest wall to be used for pacing if this should become necessary in the immediate post-operative period. If a block appears initially in the post-operative period, a pacemaker catheter is inserted through the jugular vein as previously described. Persistence of such surgically induced block for more than a month is an indication for permanent pacing.

For permanent pacing the energy source is a battery box slightly smaller than a cigarette package which is encased in an impermeable plastic and has two silastic coated wires for myocardial implantation. Our surgeons prefer to insert the pacemaker through a transverse abdominal incision in a pocket in the external oblique fascia below the belt line. The silastic wires are then carried subcostally into the left pleural cavity and attached to the apex of the left ventricle by way of a left thoractomy incision. The most commonly used pacemaker at present provides fixed rate, usually at 70-80 beats per minute. A second, more complicated device is triggered by atrial depolarization and therefore has a variable rate. The indications for a permanently implanted pacemaker are:

1. Treatment of Stokes-Adams attacks interrupting complete block or sinus rhythm.
2. Ineffective ventricular rates due to either second or third degree heart block.

To date, approximately 30% of the 50 patients with permanent pacemakers implanted at Emory University have had one or more complications attributed directly to the mechanical problems with the system, such as: wire breakage either at the battery or at the myocardium; battery failure; internal electrical malfunctions producing rate change. Post-pericardotomy syndrome occurs in about half of the patients and is well controlled with Prednisone taken orally.

Despite the difficulties with the equipment, this method of treatment has offered more reliable maintenance of cardiac function than any of the pharmacological approaches. In this series only one death was directly attributable to pacemaker failure.

*Emory University Clinic*

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.





## PRACTICAL APPLICATION OF A PSYCHIATRIC CONCEPT

J. A. Raines, M.D., *Columbus*

EXPERIENCE, observation and intensive effort through the years have provided us with reasonably accurate parameters by which we may gauge the growth and development of our children. We expect the appearance of various functional capacities in keeping with our understanding of physiological maturation. In turn, we attempt to correlate environmental expectation with the emergence of functional capability. Considerable effort is currently devoted to the formulation of a similar framework for the more intangible process which we might call the "psychological task" that is primary in importance for a given period of development. Perhaps not subject to proof, but certainly one of the most succinct expressions of this concept is the statement of the late H. S. Sullivan. He postulated the psychological task of the newborn infant as distinguishing "the me from the not me"—certainly a formidable and necessary undertaking. Current workers in this area of interest are attempting to isolate the significant psychological tasks which appear in the developmental progression from infancy to adulthood. Earlier postulates were based primarily upon reconstruction within the framework of a given theory of personality development. Efforts today combine these theoretical concepts with painstaking, direct observation permitting an immediate cross-sectional view of a given developmental period as well as the longitudinal observation over a span of months or years. Whether current concepts will survive the impact of future knowledge remains to be seen. However, in their present form they can be utilized effectively in clinical practice.

### Specifics

Let us examine a specific postulate in the context of our general experience. Between the ages of one and a half and two years children embark upon a course of behavior which has earned the sobriquet of "the terrible two's." The collective experience of mothers is such that they do not reject this term, but rather seem to nod a vigorous assent. The psychological task which has been postulated for this age is the establishment of autonomy. Does the postulated task offer any practical clues by which the impact of this developmental period can

be modified? In my opinion, it offers very substantial guides. The two-year-old who insists upon calling everything "mine" is not necessarily greedy. The two-year-old who says "me do" or simply shows evidence of anger when a door is closed is not a "spoiled brat" who is concerned solely with having his own way. Autonomy implies the freedom to possess or not possess, the freedom to imitate or ignore, the freedom to protest or agree. Perhaps above all, autonomy implies the freedom to participate on an equal footing. Quite like adults, it is the freedom rather than the act itself which is important. One of many analogies which comes to mind is the freedom to vote. Outraged if it is denied, all too often citizens do not exercise this freedom to vote when it is assured. Our two-year-old is similar in his reaction. Assured of his freedom (autonomy) he may not pursue it so vigorously. Deny him and the outrage is unmistakable. Expressed colloquially, "give the child a piece of the action!" Accept his help, but modify the form of expression. Avoid whenever possible the unequivocal "no." A simple example is to be found in the child holding an object which you wish him to surrender. A direct assault produces at least a contest, if not a conflict. Perhaps he can place it somewhere for you. In this way he preserves his autonomy by being a part of the action. However, at the same time he complies with your wish as well. Forethought and ingenuity will demonstrate a surprising range of activities, both qualitatively and quantitatively, to which this principle of giving the child a piece of the action can be applied.

### Not a Plea

This is not a plea for giving a child his every wish for fear of "frustrating" him. It is a suggestion that well within the framework of safety, cultural expectation and comfortable interaction, we can go measurably further in assisting the two-year-old to achieve a certainty of his autonomy. Hopefully, such certainty will reduce the future need to reaffirm this freedom at each and every opportunity. Perhaps in this fashion the "terrible two's" can become the "terrific two's."

*The Bradley Center*

*Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.*





# THE ASSOCIATION

## DEATHS

**GUY H. ADAMS**, 46, an Atlanta internist, died April 22, 1965, in a private hospital.

Dr. Adams, 2198 Sundown Drive NE, was born in Alexander City, Ala., but grew up in East Point. He was graduated from Emory University and the Emory School of Medicine and was an Army veteran of World War II.

He was a member of the Fulton County Medical Society, the Southern Medical Association, the Medical Association of Georgia and the American Medical Association and was on the staffs of Georgia Baptist and Crawford Long Hospitals. He attended Briarcliff Baptist Church.

Survivors include his wife, the former Ruth Beal; a daughter, Miss Beverly Adams; three sons, Donald, William and Guy Adams Jr., all of Atlanta; two sisters, Mrs. James E. Hicks, Owensboro, Ky., and Mrs. Robert P. Focht, East Point, and two brothers, Elwin K. Adams, Atlanta, and Dr. Roy W. Adams, East Point.

**F. PHINIZY CALHOUN**, 85, noted Atlanta ophthalmologist, died May 9, 1965, at Emory University Hospital.

Dr. Calhoun was a native of Atlanta, the son of Dr. Abner Wellborn Calhoun, a distinguished ophthalmologist of his day, and Mary Louise Phinizy, both of pioneer families in Georgia.

Dr. Calhoun is survived by his wife, the former Miss Marion Peel; two sons, Dr. F. Phinizy Calhoun Jr. and Lawson Peel Calhoun, both of Atlanta; one daughter, Mrs. B. W. Cardwell of Atlanta; nine grandchildren and three great-grandchildren.

Dr. Calhoun, in addition to his reputation throughout the South as one of its leading physicians in diseases and complications of the eye, was also well known for his contributions to education at both Emory University and the University of Georgia.

He established a lectureship at the University of Georgia in memory of Ferdinand Phinizy, his grandfather. At the School of Medicine of Emory University, he, with other members of his family, established and endowed the Medical Library as a memorial to his father, who was the first professor of ophthalmology of the Atlanta Medical College (now Emory). The Ferdinand Phinizy Calhoun Chair of Ophthalmology at Emory was established in 1960 in honor of Dr. Calhoun.

### Georgia Graduate

Dr. Calhoun was educated in the public schools of Atlanta and was graduated from the University of Georgia in 1900 with the degree of Bachelor of Arts. For one year he attended Harvard College and the following year entered the Atlanta College of Physicians and Surgeons (now Emory's Medical School). He graduated in 1904.

He served his general internship at Grady Hospital, and received his training in ophthalmology at the New York Eye and Ear Infirmary, graduating in 1907. He also studied in Vienna.

Dr. Calhoun returned to Atlanta and joined his father in the practice of ophthalmology. On his father's death in 1910, he succeeded him as head of the department of ophthalmology in the medical school and as visiting ophthalmologist at Grady Hospital.

### High Offices

He has served on the staffs of Grady, Wesley Memorial (now Emory), and St. Joseph's hospitals.

He was a member of the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association, the American Academy of Ophthalmology and Otology, the American Ophthalmological Society (president in 1941), and a fellow of the American College of Surgeons (second vice president in 1941).

He was a veteran of World War I, serving in the medical corps with the rank of major.

### Alumni Leader

He was a former president of the Alumni Society of the University of Georgia, and in 1937 received from the society the first Alumni Award. He also was a president of the Alumni Society of the New York Eye and Ear Infirmary, chairman of the Board of Trustees of the University of Georgia Foundation, a member of the executive committee of the Board of Trustees of Emory University, a trustee of the Joseph Brown Whitehead Foundation, and a member of the local advisory board of the Citizens and Southern National Bank.

He was a deacon emeritus of the First Presbyterian Church, and a member of the Piedmont Driving Club and the Capital City Club of Atlanta.

In 1954 he was granted the honorary degree of Doctor of Laws by Emory University. He was a member of the honorary societies of Alpha Omega Alpha, Omicron Delta Kappa, and Phi Beta Kappa. He was a member of the Chi Phi fraternity.

**EDGAR M. LANCASTER**, 75, of Shady Dale, died April 2, 1965, at Jasper Memorial Hospital following a brief illness.

He is survived by his wife, the former Miss Jewel Moats of Fairburn and one brother, Alva Lancaster of Shady Dale.

He served as Camp Physician for the Putnam Prison Branch for the past eight and one half years.

Dr. Lancaster was a life-long resident of Shady Dale.

He was a member of Providence Baptist Church and served as moderator of the Central Baptist Association on several occasions. A graduate of Mercer University and Emory University School of Medicine, Dr. Lancaster served his internship at St. Joseph's In-



## THE ASSOCIATION / Continued

firmly in Atlanta and practiced medicine in Atlanta for two years before returning to his native Jasper County where he practiced medicine in Shady Dale and Monticello for 42 years.

Dr. Lancaster was interested in several organizations. Among them were The American Legion, having been a veteran of World War I, Kiwanis, Masonic Lodge, Scottish Rite in Macon, York Rite and Yaraab Temple Shrine in Atlanta (a member of the First Hundred Club), a past Grand Officer of the Order of Eastern Star. He was State Senator in 1951-52 from the 28th Senatorial District composed of Jasper, Putnam, and Morgan Counties and was correspondent for *The Monticello News* and *The Eatonton Messenger* for many years.

WILLIAM PARKS PHILLIPS, 71, LaGrange, died April 16, 1965, at City-County Hospital. He had been in declining health for the past several months.

Dr. Phillips was a native of Milner, Georgia.

He graduated from the Atlanta Medical College in 1915, then did postgraduate work at the New York City Foundling Hospital. He served in the Medical Corps during World War I and has practiced medicine in LaGrange since 1919, following his discharge.

Phillips was a member of the Georgia Medical Association, Troup County Medical Association and an Elder of the First Presbyterian Church.

Survivors include his wife, Mrs. Mary Healy Phillips of LaGrange; two daughters, Mrs. William T. Richards and Mrs. Lewis R. Morgan, both of LaGrange; two sisters, Mrs. Mary Emma Broadhurst and Mrs. William Calhoun, both of Atlanta and four grandchildren.

JEFF L. RICHARDSON, 64-year-old Atlanta cardiologist, died May 9, 1965, at his home.

A native of College Park, he attended old Boys High and was graduated from Emory University and the Emory Medical School. He began practice in Atlanta in 1927.

Dr. Richardson was a veteran of World War I and was a former president of the Fifth District Medical Society.

He was a former trustee of the Georgia Heart Association and had served as co-director of the Giddings Memorial Heart Clinic. He was on the staffs of St. Joseph's Infirmary and Crawford Long and Georgia Baptist hospitals. He was a former chairman of the board of governors of St. Joseph's Infirmary.

Dr. Richardson was a member of St. Luke's Episcopal Church, the Atlanta Art Association, the Druid Hills Golf Club and Sigma Alpha Epsilon fraternity.

Survivors include his wife, the former Lucille Matt; three daughters, Mrs. Jack Anderson, Atlanta; Mrs. James K. Ford, Louisville, Ky., and Mrs. Harry L. Tucker, Winter Park, Fla., and two brothers, Edward Richardson Sr., College Park, and Leaver Richardson, Atlanta.

## SOCIETIES

FIRST DISTRICT MEDICAL SOCIETY met April

7 at Statesboro. Theodore B. Schwartz, M.D., Director of the Section of Endocrinology and Metabolism, Presbyterian-St. Luke Hospital, Chicago, was the guest speaker. Mark Brown, M.D., Professor of Radiology, Medical College of Georgia, Augusta, gave a lecture on "The Impact of Image Amplification."

Newly elected officers for the coming year are John D. Deal, M.D., President; Jeff Holloman, M.D., President-Elect; Emory Bohler, M.D., Vice President; V. J. Cirincione, M.D., Secretary; and L. F. Lovett, M.D., Treasurer.

A former Savannahian, Richard C. Britton, M.D., nationally recognized surgeon, was the guest speaker at the April 1 meeting of the GEORGIA MEDICAL SOCIETY, Savannah. Dr. Britton, who served as a member of the surgical staff at Hunter Air Force Base for 1951-53, is now Assistant Professor of Surgery at Columbia-Presbyterian Medical Center, New York City. His topic was, "Twenty Years' Experience with Treatment of Portal (Liver) Hypertension: Results and Treatment."

McDUFFIE COUNTY MEDICAL SOCIETY held its recent meeting in Thomson to discuss methods of controlling the mosquito which is the transmitter of sleeping sickness and other viruses. R. McCroan, M.D., of the State Health Department, Atlanta, was the guest speaker.

NINTH DISTRICT MEDICAL SOCIETY met April 21, 1965, at Gainesville. HALL COUNTY MEDICAL SOCIETY was host. After the business meeting, a Program, "Symposium on the Acute Abdomen," was held with guest speakers from Emory University School of Medicine and the Medical College of Georgia participating: John T. Galambos, M.D.; Richard Blumberg, M.D.; and J. D. Martin, M.D., Emory Medical School, and C. I. Bryans, M.D., Medical College of Georgia.

The SECOND DISTRICT MEDICAL SOCIETY held its Spring meeting April 8, 1965, at Sylvester. Joe Sam Robinson, M.D. of Macon presented a paper on respiratory diseases, and Randolph A. Malone, M.D., of Thomasville presented a paper on the diseases of children as they affect the foreign missionary. Officers for 1965 were elected at this meeting. They are: Frank M. Gay, M.D., Moultrie, President; H. B. Jenkins, M.D., Donalsonville, Vice President; and W. P. Stoner, M.D., Sylvester, Secretary-Treasurer.

SEVENTH DISTRICT MEDICAL SOCIETY met in April at Rome. Guest speakers included Arthur White, M.D., Medical College of Georgia, Augusta; Thomas Sellers, Jr., M.D., Emory University School of Medicine, Atlanta; and Louis P. Jevery, M.D., Medical College of South Carolina, Charleston.

## PERSONALS

### Second District

HENRY S. PEPIN, JR., Thomasville, has been elected President of the medical staff of John D. Archbold Memorial Hospital. Other new officers are E. E.



DAVIS, President-Elect; J. J. COLLINS, Secretary; and JOHN T. KING, Treasurer.

**Third District**

J. C. LOGAN, Plains, has recently been cited for his "outstanding service in the practice of medicine" by the Medical College of Georgia. In his eighties, Dr. Logan, who has served as mayor of Plains, is among 300 physicians in Georgia who have practiced for 50 years or are over 75 years old, to be so honored.

DAVID WETHERBY, Fort Gaines, was featured in a recent article in the Sunday magazine section of the *Gainesville Ledger-Engineer*. In addition to practicing medicine, Dr. Wetherby is also the town's mayor.

**Fourth District**

ERNEST PROCTOR of Newnan was the guest speaker at the regular monthly meeting of The Conservatives held in Manchester, Georgia, in March. Dr. Proctor, who is Chief of Staff of Coweta General Hospital spoke on the provisions of the proposed Medicare Bill.

**Fifth District**

J. FRANK WALKER of Atlanta has recently been elected President of the Emory University Medical Alumni Association. Other newly elected officers are CHARLES HOLLIS, Albany, Vice President; UPTON

CLARY, Savannah, Secretary-Treasurer; and THOMAS J. ANDERSON, Atlanta, and PIERPONT BROWN, Gainesville, Trustees. HARRISON L. ROGERS, Atlanta, is outgoing President.

J. L. IZENSTARK, Atlanta, spoke to a combination meeting of the Floyd County Medical Society and the Rome Shriner's Club on "What, How and Why of Nuclear Medicine."

R. BRUCE LOGUE, Atlanta, recently participated in a Seminar on Diseases of the Heart at a meeting of the College of American Pathologists Gulf Region and Atlanta Society of Pathologists.

**Tenth District**

General Practitioner, C. H. DICKENS, of Madison has recently been honored by the Medical College of Georgia, Augusta, for his outstanding service in the field of medicine. The certificate which Dr. Dickens received entitles him to complimentary enrollment in all continuing medical education courses at the Medical College of Georgia. Dr. Dickens has practiced medicine in Morgan County for 50 years.

D. N. THOMPSON, Elberton, has also received a certificate of appreciation from the Medical College of Georgia. Dr. Thompson has practiced medicine in Elberton for 57 years.

**SUMMARY OF RECENT MAG COUNCIL AND EXECUTIVE COMMITTEE ACTIONS**

*(The full minutes from which these summaries have been abstracted are available to any MAG member upon request to the Journal.)*

**Executive Committee of Council / March 27, 1965**

Approved: Dr. Atwater's Treasurer's Report  
Accepted: Auditor's Report as presented  
Received for Information: Professional Conduct report—further action to be taken.

Recommended: That Trip Travel Insurance for MAG members and employees be purchased. Insurance would cover the following: All employees (both full and part time, Councilors and Vice Councilors, Officers, Board and Committee and Subcommittee members, Members and Alternates of the House of Delegates, Consultants and Conferees, and Members of the Policyholder who (whether or not compensated for time and expense) travel in the interest of the policyholder's business. Also any Officer whose term of office expires during a meeting or semi-annual meeting sponsored or co-sponsored by the Policyholder. Coverage would be for twenty-four (24) hour business travel and sojourn inside or outside city limits, excluding policyholder owned/operated aircraft. The benefits would be \$25,000 accidental death and dismemberment; aggregate limit of indemnity (any one accident) \$500,000. The premium would be \$353.50. Mr. Krueger was asked to verify if the insurance would cover any member when attending the Association's Annual Session.

Recommended that MAG Subcommittee Report on Cancer be reported to Council with recommendation that any action be delayed until it is learned what will happen to HR 6675.

Voted: By the Executive Committee to approve the report of the Interprofessional Council (changes in the wording of the action taken by the group composed of MAG Maternal and Infant Welfare Subcommittee members, MAG Interprofessional Council members and representatives of the Georgia Pharmaceutical Association). Motion passed by the group is quoted below, with changes recommended by the Interprofessional Council in italics:

"It was recommended that another letter be written the State Board of Health by the Interprofessional Council that after

consideration by all parties concerned, the Interprofessional Council would endorse the following: (1) Family Planning; (2) The use of intrauterine devices; and (3) The use of oral contraceptives with the following conditions: (a) *When prescribed or dispensed by a physician;* (b) *For additional distribution—a vendor system should be established under licensed pharmacists in accordance with the laws governing the distribution of legend drugs."*

Pilot Program for Two Year Nursing School: Letter received from MAG representative on Joint Council on Paramedical Education that group was proposing a two-year nursing program associated with one or more of junior colleges in state. The plan would not include clinical training after the two year schooling. Voted to inform the representative that the Association feels that anyone receiving a nursing license should have clinical experience, and that on the basis of information given, training would be inadequate under the suggested program.

Approved: Distribution, by the State Department of Public Health to its members, of a pamphlet titled, "Screening and Diagnosis in Diabetes Mellitus for the Physician."

Headquarters Office Report: (1) Recommended that a committee be appointed to study recommendations, concerning paramedical ed. made by the 1964 House of Delegates and report back to Council; Executive Committee voted to follow this recommendation. (2) Executive Committee was informed that Julian Quattlebaum, Jr., Savannah, of the First District, and D. B. McRae, McRae, of the Eighth District, have been appointed by the Governor to the State Board of Health. (3) Georgia Radiological Society prefers that two members of this Advisory Committee be appointed by MAG. Executive Committee requests that report of the Committee be made to MAG; Mr. Krueger was asked to contact Dr. Marvin Silverstein, member of the committee, for clarification. (4) Resignation of Dr. Thomas W. Goodwin as Alternate Delegate to AMA; Alternate Delegate to be elected to replace him at 1965



Annual Session. (5) Dr. George Dillinger stated his intention to resign as Alternate Delegate to AMA and was asked to submit a letter of resignation. (6) Executive Committee voted to recommend to Council the following to receive Certificates of Appreciation:

MAG President, MAG Auxiliary President, First Vice President, and.

(1) Harry Pinson, Augusta, for Relative Value Study  
(2) Linton H. Bishop, Atlanta, for service as Chairman of the Public Service Board

(3) Charles T. Cowart, LaGrange, for service as Chairman of the Georgia Hospital-Medical Council

(4) J. Rhodes Haverty, Atlanta, for service as Chairman of the Weekly Health Column Subcommittee

(5) Mr. Richard Nelson, Chicago, for service to MAG as AMA Field Representative

(6) Eugene L. Griffin, Atlanta, for outstanding service as Chairman of the Maternal and Infant Welfare Subcommittee

(7) W. D. Stribling, Gainesville, for outstanding service as Chairman of the Mental Health Subcommittee

(8) Joseph B. Mercer, Brunswick, for service as Vice Speaker of the House of Delegates and outstanding devotion to the Association.

(7) Approval by Executive Committee of recommendation that Bylaws be amended to allow the Immediate Past President to serve on Council for 3 years, the first year of Executive Committee and an additional 2 years as an ex-officio member of Council. Executive Committee recommended that it be referred to Council and then to Constitution and Bylaws Board for consideration. (8) Dr. Dillinger stated that Thomas-Brooks County Medical Society would submit nomination for affiliate membership of Dr. Albert C. Tuck, a Past President of the Georgia Dental Association, to Council. (9) Suggestion that April meeting be conducted by a telephone conference.

#### Council Meeting / March 27-28, 1965

Received:

**REPORT OF TREASURER**—Dr. Atwater reported on the following:

(a) *Treasurer's Report*: On motion duly made and seconded this report was accepted.

(b) *Auditor's Report*: On motion duly made and seconded this report was accepted.

(c) *Contribution to Retirement Fund*: On motion duly made and seconded it was voted to allot \$2400 for the year 1964 with funds to be taken from the general fund.

(d) *Taxes Appropriation*: On motion duly made and seconded it was voted that \$4000 be earmarked in the general fund for the payment of taxes.

(e) *Membership Expense Reimbursement Policy*: On motion duly made and seconded the Membership Expense Reimbursement Policy was adopted.

(f) *Contingent Fund Appropriation*: On motion duly made and seconded it was voted that \$5000 should be taken from the general fund, plus the \$1155 which was the overage from the year 1964, and both amounts transferred to the Contingent Fund.

Received for Information: Dr. Goodwin's report on the Medical Education Conference in January at Callaway Gardens and meeting of the Board in Macon at which time continuing postgraduate medical education and the possibility of establishing GP postgraduate residencies at some non-university general hospitals over the state were discussed.

Voted: To Approve Catastrophic Insurance for MAG employees who have been with the association for two years or more; purchase to be from Life of Georgia and funds to be taken from the Contingent Fund.

Voted: To purchase Workman's Compensation insurance for the Association's employees with funds to be taken from the Contingent Fund.

Recommended: That Areawide Health Planning Facilities Meeting be held and that request made by Dr. Napier Burson for funds be approved by Council; funds to be taken from the MAG Sundry Account, amount not to exceed \$100.

Recommendations: Of the MAG Mental Health Subcommittee re Local Mental Health Centers; suggested two additions to the seven in report be added:

"(8) That the MAG Council should recommend to the Mental Health Division of the State Department of Health that all of the clinics should have a physician director, either full or part time.

"(9) That all patients should be referred to the clinic by a physician with sufficient notification and consent of the parent or nearest relative."

Voted that with the addition of the above points, the report of the Mental Health Subcommittee be approved and referred to the House of Delegates with Council's approval.

Received: AMA Field Representative Richard Nelson's report on the status of pending legislation (HR 6675); and the interest stimulated by the Medical Education Conference held at Callaway Gardens.

Voted: That suggestion that MAG Woman's Auxiliary dues be collected in combination with county medical societies be deferred; revision of Auxiliary Constitution and Bylaws was also discussed.

Report on Legislation:

(a) *National Legislation*: HR 6675, the pending "Medicare" legislation.

(b) *State Legislation*: The Georgia General Assembly actions were as follows:

(1) Appropriations Bill—\$1.2 million appropriated for implementation of MAA in 1966.

(2) Voluntary Sterilization Bill—was not reported out of Senate Committee.

(3) Anti-Child Abuse Bill—Passed.

(4) Marriage Laws Bill—Passed with changes such as elimination of three days waiting period for people over 21 years of age.

(5) Post Mortem Bill—Did not pass. This bill would have limited post mortems for the sole purpose of determining cause of death and if any organ or part of the body were removed it would have to be returned to the body before being sent to the funeral home.

(6) Drivers License Bill—Did not get out of committee. The bill, sponsored by MAG, would have required all people age 65 and over to resubmit to a drivers license examination each five years to determine if they could still operate an automobile safely. As the committee was more concerned with the automobile inspection law, they did not wish to consider this other bill this year.

(7) Fluoridation of Atlanta Water Supply Bill—Did not pass.

Received for information: Summation of the bill HR 6675, which combines King-Anderson, Byrnes, Mills, M.D. compulsory inclusion under Social Security, and 7% cash benefits features.

Received: Information on Relative Value Schedule; Dr. Pinson reported that the Relative Value Study results had been mailed to MAG Delegates, County Society Presidents and Secretaries and members of Council as authorized by Council.

Report received: Dr. McDaniel stated that the Medical Typists Course at Augusta wished to be approved by the MAG and use the name of the Association on its certificates. Dr. McDaniel was asked to write Dr. Harkess, Chairman of the Committee on the typists course, to inform him that while the association supports this type of activity, it cannot allow its name to be used in connection with a seal of approval.

Information received: Mr. Krueger informed Council that Atlanta would have facilities for an AMA Clinical Convention by 1968 and asked for Council's approval. Voted to enthusiastically endorse the idea; Dr. Simpson was asked to invite the AMA to meet in Atlanta in 1968.

Submitted for Council Approval: Resolution to change Bylaws regarding Immediate Past President to read as follows:

"WHEREAS, the Bylaws provide for a retiring President of MAG to serve as a member of Council for only one year, and

"WHEREAS, this short term means loss of valuable knowledge and experience to the Medical Association of Georgia,

"THEREFORE BE IT RESOLVED, that Section 1 of Chapter IV of the Bylaws be amended by inserting at the end of line 2 following 'the immediate Past President, who shall serve as a full member of Council for a period of three years.'

"BE IT FURTHER RESOLVED, that Section 5 of Chapter VI of the Bylaws be rewritten to read as follows: 'Section 5. Immediate Past President. The Immediate Past President shall serve as Immediate Past President for a term of one year following his term of office as President and as such shall serve on Council and its Executive Committee. The following two years he shall continue to serve as a member of Council.'

"The foregoing shall be retroactive where it applies."

Voted to approve the above resolution and refer it to the Constitution and Bylaws Board for consideration with referral back to Council for submission as a supplemental report by Council to the House of Delegates at the Annual Session.



**JOURNAL**  
OF THE MEDICAL  
ASSOCIATION

JULY/1965

Georgia

U.C. MEDICAL CENTER LIBRARY

AUG 4 1965

San Francisco 94122



## **The Adopted Child**

**See page 247**





Russian Thistle  
(*Salsola pestifer*, A. Nelson)

Distress for Allergic Patients

**Benadryl<sup>®</sup>**  
(diphenhydramine hydrochloride)  
PARKE-DAVIS

## To Combat Symptoms of Weed-Pollen Allergy

This time-tested agent provides two actions that effectively combat symptoms of seasonal allergy: *Antihistaminic*—relieves sneezing, nasal congestion, itching, and lacrimation. *Antispasmodic*—relieves bronchial and gastrointestinal spasm. **Precautions:** Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers, if used with BENADRYL, should be prescribed with caution because of possible additive effect. Diphenhydramine

has an atropine-like action which should be considered when prescribing BENADRYL. **Side Effects:** Side reactions, commonly associated with antihistaminic therapy and generally mild, may affect the nervous, gastrointestinal, and cardiovascular systems. Most frequent reactions are drowsiness, dizziness, dryness of the mouth, nausea, and nervousness. BENADRYL is available in Kapseals<sup>®</sup> of 50 mg. and Capsules of 25 mg. diphenhydramine hydrochloride. The pink capsule with the white band is a trademark of Parke, Davis & Company.

**PARKE-DAVIS**

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232

72665





JOURNAL  
OF THE MEDICAL  
ASSOCIATION

Georgía

Contents

EDITOR

Edgar Woody, Jr., M.D.

MANAGING EDITOR

Miss Merrilie M. Davis

STAFF

Thelma V. Franklin, *Business*

CONTRIBUTING EDITORS

Herbert S. Alden, M.D.; Preston D. Ellington, M.D.; Thomas Findley, M.D.; J. Willis Hurst, M.D.; Charles S. Jones, M.D.; Arthur M. Knight, Jr., M.D.; Arthur J. Merrill, M.D.; Lester Rumble, Jr., M.D.; Peter L. Scardino, M.D.; Patrick C. Shea, Jr., M.D.; Robert H. Vaughan, M.D.

PUBLICATIONS COMMITTEE

J. G. McDaniel, M.D.; George H. Alexander, M.D.; George R. Dillinger, M.D.; John Kirk Train, M.D.; A. W. Simpson, M.D.; John T. Mauldin, M.D.; John S. Atwater, M.D.; C. R. Andrews, M.D.

THE ASSOCIATION

George H. Alexander, M.D., *Pres.*; Walter E. Brown, M.D., *Pres.-Elect*; J. G. McDaniel, M.D., *Past Pres.*; Charles R. Andrews, Jr., M.D., *Chm. of Council*; John T. Mauldin, M.D., *Sec.*; John S. Atwater, M.D., *Treas.*; J. Frank Walker, M.D., *Speaker*; Mr. Milton D. Krueger, *Exec. Sec.*; Mr. James M. Moffett, *Asst. Exec. Sec.*; Mrs. Catherine Wooten, *Asst. Exec. Sec.*

THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and copyrighted, 1965, by the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309. Published monthly under the direction of the Council of the Association. Subscription rate: \$7 per year; \$1 per single copy. Second-class postage paid at Atlanta, Georgia.

Scientific Articles

CHONDRO-OSTEO-DYSTROPHY MORQUIO-BRAILSFORD SYNDROME IN A 49-YEAR-OLD NEGRO MALE Arthur M. Knight, M.D. . . . .	243
NORMAL PROBLEMS IN ADAPTING TO ADOPTION Martha McCranie, M.D. . . . .	247
NUTRITIONAL DISEASE IN GEORGIA F. J. Clune, Jr., Ph.D. and Ira E. Robinson, Ph.D. . . . .	252

Editorials

WELCOME ABOARD . . . . .	254
THE USE OF ANTIMETABOLITES IN "CONNECTIVE TISSUE" AND "AUTOIMMUNE DISEASES" . . . . .	254
AREA-WIDE HOSPITAL PLANNING—WHAT IS IT? . . . . .	255
AFTER MEDICARE, WHAT? . . . . .	256
MAG 1965 ON RELATIVE VALUE STUDY . . . . .	257

Features

President's Letter . . . . .	258
Cancer Page . . . . .	259
Heart Page . . . . .	261
Legal Page . . . . .	262
Abstracts . . . . .	263

The Association

Societies . . . . .	265
Personals . . . . .	265
Advertising Index . . . . .	48A
Calendar . . . . .	251

Cover

Staff photo



In Dynamic DeKalb . . .

The Focal Point for Professional People

## DECATUR FEDERAL NORTH

Church and Barry Streets—Adjacent to Decatur Federal Building

Modern in Every Respect—Radiological Department; Pathological Laboratory; EEG Unit; Physiotherapy Unit; Unique Electronic Computer Billing Service; Radio-Controlled Answering Service; Medical Secretarial Service; Plus Many Other Appealing Features and AMPLE PARKING

Now Leasing for Occupancy in Early 1966

**Buck Bothwell, W. P. Tatum Company**, exclusive agent

Decatur Federal Building—373-5716



## CHONDRO-OSTEO-DYSTROPHY

### MORQUIO-BRAILSFORD SYNDROME IN A 49-YEAR-OLD NEGRO MALE

Arthur M. Knight, M.D., *Waycross*

**I**N REVIEWING the literature on Morquio's disease, one finds that approximately 60 cases have been reported and that the reports are on childhood cases and in pediatric journals. Both Morquio and Brailsford described the syndrome in children, and pediatricians are aware of it. But it appears that internists have not been familiar with chondro-osteo-dystrophy, and the writer was unable to find a report on a middle-aged male.

#### Familial Defect

Morquio's syndrome is a familial defect in the development of skeletal tissues which results in dwarfism (Figures 1, 2) with shallowness of the

■ **This rare familial defect is predominantly seen in children.**

vertebral bodies (Figures 3, 4, 5), kyphosis, and progressive changes in the femoral head (Figure 6) in a child of normal intelligence. It affects the whole skeleton to a varying extent, with the exception of the bones of the skull and face. X-rays show platyspondyly (flat vertebrae) (Figure 7) or wedge deformities of vertebrae, as well as enlargement of



Figure 1.  
Anterior view of patient J. G.



Figure 2.  
Right posterior oblique view of patient J. G.

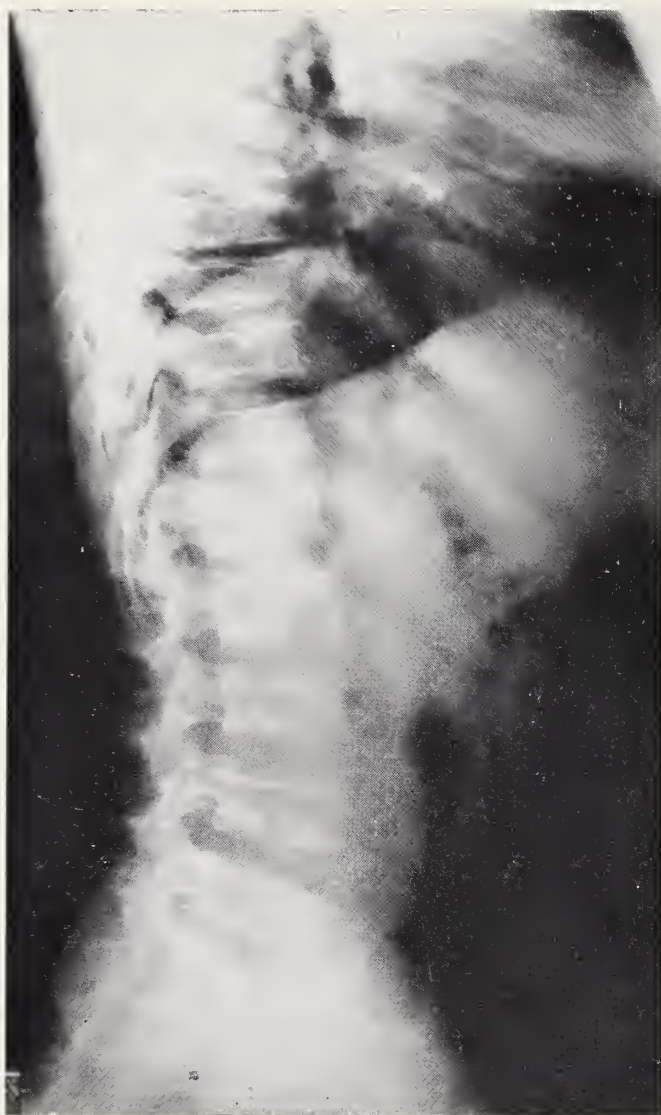


Figure 3.

Lateral spine of J. G. showing Morquio deformity (platyspondyly).

epiphyses in the extremities (Figure 8). The flat vertebrae cause a diminution in the vertical measurement of the chest and a shortening of the neck (Figure 9). Knock-knee and flat feet are usually present. Marked deformities and secondary degenerative changes are seen in the joints of the extremities, especially hip, knee, and ankle (Figure 10).

### Case History

J. G. is a 49-year-old unmarried Negro male (Figures 1, 2) who was examined on September 30, 1964, at the request of the Social Security Administration, for the purpose of determining the extent of his physical disability. He had continued to earn his own living until two years before. Although he had been somewhat dwarfed since birth, he noticed no joint pain or stiffness before age ten years and was not aware of his spinal deformity before age 15 years. He now complained of pain and limitation of motion of all the major joints of all four extremities, the most painful being the left knee.

Physical examination (Figures 1, 2) revealed a

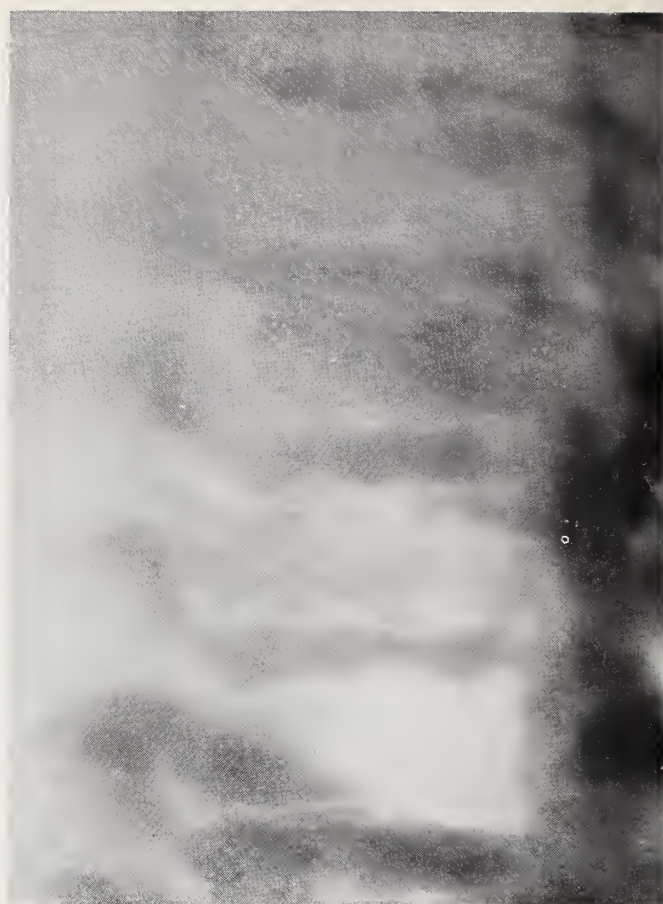


Figure 4.

Enlarged lateral view of spine to show platyspondyly.

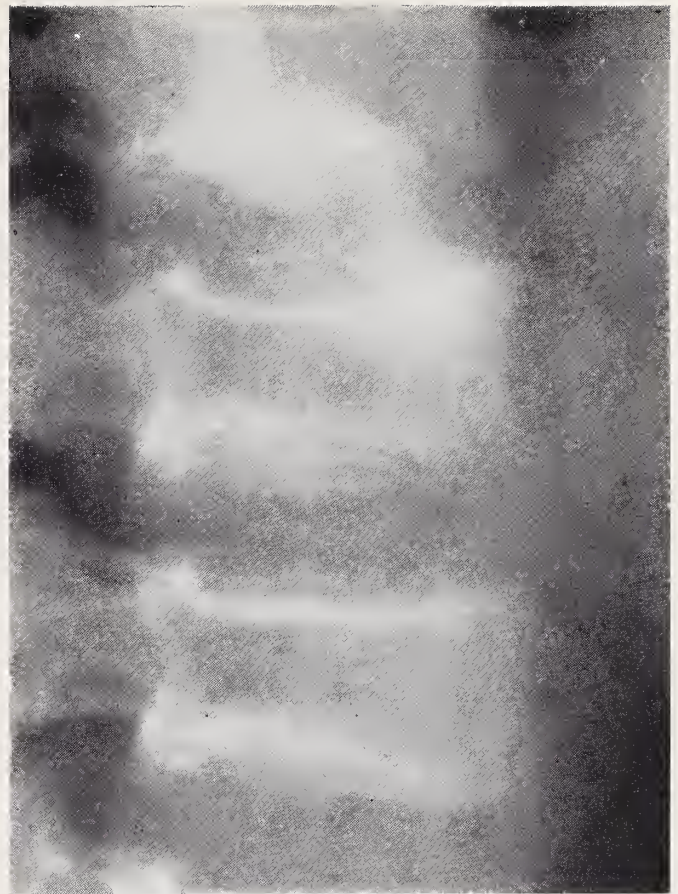
markedly deformed, middle-aged Negro male with an intelligent face, short neck, short trunk, crooked spine, prominent chest, twisted pelvis, markedly deformed left knee and left ankle with greatly diminished mobility, and flat feet. The left leg was displaced laterally  $30^\circ$  with reference to the left thigh. There was mild scoliosis with convexity to the left in the dorso-lumbar area. The right iliac crest was elevated 5 cm. higher than the left, causing the right lower extremity to appear shorter than the left. His height was 157.8 cm., span 156 cm., trunk 55 cm. (vertical measurement), upper extremities 78 cm., lower extremities 100 cm. (anterior superior iliac spine to sole of foot). There was enlargement and deformity of most of the weight-bearing joints (Figures 6, 8, 10) and marked limitation (50% loss) of motion of both hips. Motion in the right shoulder was limited slightly (10% loss). The distal extremity of the right ulna was enlarged and there was 20% loss of motion in the right wrist. Motion in the right knee was reduced 25% and in the left knee 70%.

The patient also had hypertensive arteriosclerotic cardiovascular disease with a blood pressure of 180 to 190 systolic and 100 to 130 diastolic. He had a large left ventricle and a dilated, enlarged thoracic aorta.





**Figure 5.**  
Normal lateral spine for comparison.



**Figure 7.**  
Vertebral bodies showing platyspondyly. (Note relatively wide disk spaces.)



**Figure 6.**  
Pelvis showing deformity and degenerative changes in femoral heads and acetabula.



**Figure 8.**  
Left knee to show faulty osseous development and marked secondary degenerative changes.





Figure 9.  
Platyspondyly of cervical vertebrae producing short neck.



Figure 10.  
Left ankle showing marked degenerative changes.

## Comment

The children described by Morquio and Brailsford did not live to be adults. Those described in other reports became severely crippled at a relatively early age and required help from others. Some authors emphasize severe muscular weakness, a finding not present in our case. In many childhood cases there is hypermobility of joints due to delayed ossification, as in the wrist and ankle, but this would undoubtedly progress to rigidity if the child survived to permit the pathological process to progress. If this cause for joint disability is kept in mind, many other cases of chondro-osteo-dystrophy will probably be recognized by generalists, internists, and orthopedists.

## Summary

A case of chondro-osteo-dystrophy in a 49-year-old Negro male is reported. This is thought to be the only reported case in a middle-aged adult. The salient features of this syndrome are described and photographs of the patient and x-rays of his skeleton are presented.

P. O. Box 899

## Bibliography

1. Brailsford, J. F.: Chondro-osteo-dystrophy, *American Journal of Surgery*, 7:404-410, 1929.
2. Morquio, L.: *Archives de Medecine des Enfants* 32: 129-140, 1929.
3. Meyer, H. F., and Brennemann, J.: A Rare Osseous Dystrophy (Morquio), *Am. J. Dis. Child.*, 43:123, 1932.
4. Barnett, E. J.: Morquio's Disease, *J. Pediat.*, 2:65, 1933.
5. Brown, D. O.: Morquio's Disease, *M. J. Australia*, 1:598, 1933.
6. Coward, N. R., and Nemir, R. T.: Familial Osseous Dystrophy. *Am. J. Dis. Child.* 46:213, 1933.
7. Ellman, P.: A Rare Primary Osseous Dystrophy, *Brit. J. Child. Dis.* 30:188, 1933.
8. Summerfeldt, P., and Brown, A.: Morquio's Disease: Report of Two Cases, *Arch. Dis. Child.* 11:221, 1936.
9. Crawford, T.: Morquio's Disease, *Arch. Dis. Child.* 14:70, 1939.
10. Pohl, J. F., Osteodystrophy (Morquio's Disease): Progressive Kyphosis From Congenital Wedge-Shaped Vertebrae, *J. Bone and Joint Surg.* 21:187, 1939.
11. Einborn, N. H.; Moore, J. R.; Ostrum, H. W., and Roundtree, L. G.: Osteochondrodystrophia Deformans (Morquio's Disease). Report of Three Cases, *Am. J. Dis. Child.* 61:776, 1941.
12. Einborn, N. H.; Moore, J. R., and Roundtree, L. G.: Osteochondrodystrophia Deformans (Morquio's Disease), Observations at Autopsy in One Case, *Am. J. Dis. Child.* 72:536, 1946.
13. Brailsford, J. F.: *Radiology of Bones and Joints*, 4th ed., 1948, p. 562-70.
14. Whiteside, J. D., and Cholmeley, J. G.: Morquio's Disease, Review of Literature With Description of 4 Cases, *Arch. Dis. Child.*, 27:487, 1952.
15. Zellweger, H.; Giaccari, L., and Firzli, S.: Gargoylism and Morquio's Disease, *Am. J. Dis. Child.*, 84:421, 1952.



# NORMAL PROBLEMS IN ADAPTING TO ADOPTION

Martha McCranie, M.D., *Augusta*

- From the study of the adoptive process, it would seem that the adoptive parent needs to be more mature than a physical parent.

IN MY OUTPATIENT psychiatric experience with children and parents, I obtained the impression clinically that an undue percentage of those children referred for help with emotional problems were adopted children. It also was noticeable that the problems presented, though similar to those of other children seen, were presented by the adoptive parents in a fashion quite different from the way a natural born parent might present the same problem in his child; and, further, that the adoptive child himself responded to the psychiatric interview situation and the implications of the problem in a way dissimilar to a child raised by natural born parents.

## Different Response

My contact with children in a state operated (S.C.) school for dependent children (most of whom are there due to failure of the family to provide adequate nurturing care for the child) was conducive to additional observations on my part, that a disproportionate number of children in the school were from adoptive homes, and that those who were from such homes responded to placement in the school in a manner different from the child coming from his natural home. This difference seemed to be due to the general personality make-up of the child and was apparent in both the child's feelings about himself, and in the ways he made his adjustment to his own inner growth and maturity as well as to the external environment of the school.

Another psychiatrist, Schechter, has documented statistically significant evidence that the number of non-relative adoptee patients with emotional problems is highly elevated in child guidance clinics, a state hospital, private residential treatment centers, and in private psychiatric practices.

This paper is an attempt to document insights gained in further observations and study as to the nature of the adoptive process, what is unique to it, what needs to be done to facilitate healthy adaptation to it, what pitfalls occur along the way in the growth of the adoptive family, and what patch-up work along the way can be of use to the child.

## Psychological Concepts

Although there are many interesting facets of the adoptive process which could well be discussed, this paper is confined to a presentation of only the psychological concepts which are peculiar to adoption and adoptee. It does not include very important knowledge and facts about the methods of adoption, the framework by which adoption can be effected in Georgia, the special problems related to the adoption of older and physically or mentally handicapped children, the additional special problems related to adopted children of other nationalities, or the psychiatric treatment of those adopted children who flounder in the process of their psychological adjustment.

First, it is important to understand the psychological work that must be done by the parties involved in the adoption prior to the adoptive parents' actually obtaining the child. There is psychological work to be done by the natural parent, there is work that must be done by the adults desiring to adopt the child, and, if the child is above the age of infancy when adopted, he needs to have dealt with certain feelings and thoughts involved.

Needless to say, the natural parent who needs to give up a child, has problems (financial, emotional, genetic, or otherwise) which lead to his inability to raise the child born to him. Although such a person may need a great deal of help in dealing with such problems, this in itself is not germane to the psy-

chological work needed in giving up the child. It is, however, necessary that the natural mother come to the feeling within herself that since she cannot give the child what he needs that she will be a "good mother" by giving her child up to a family who can provide a healthy, happy home. Having satisfied her emotional needs in relation to that life which she carried during its beginnings, she can then discharge her responsibility in a manner that leaves the child and its future care-takers the freedom to proceed unhindered by the later return of a natural parent intent on repossession of her child. Facilitation of this psychological process is made possible when the child is turned over to reliable agencies who respect the need for natural parent and adoptive parent to be forever unknown to each other.

### **Work Is Complex**

The psychological work which the adoptive parents need to do prior to obtaining a baby is quite complex. It involves: 1. factors related to the parent himself and 2. factors related to the parents' thoughts about the natural mother. Of importance in relation to the former are: the personality make-up of each parent, the marital relationship between the two, the assessment of the reason for the infertility of the couple, the experiencing of and resolving the grief associated with not being able to give birth to children of one's own, the resolution of any feelings of resentment or bitterness toward one party if only one is found to be sterile, the trial of substitute ways of satisfying parental needs, and finally the decision that the marital pair has something positive to give in raising a child; this being denied them by natural birth, they would like to give of themselves to some child who needs them. As can be seen from this, the parents need to do much analyzing, experiencing, and understanding of themselves, their relationship with each other, and their relationship to their childlessness following which they come out of their grief and resentment with an acceptance that, in spite of this inability to conceive on their parts, they have something to offer and want to give it to a person who likewise has already experienced an unfortunate act at the hands of fate.

It is of interest, and significance, that those parents in whom organic pathology has been documented as being responsible for the infertility of the parent are better and more quickly able to do the psychological work which must be done for the adoption to get off to a good start. Those parents in whom demonstrable organic reasons for infertility are not found have a more difficult psycho-

logical task. Since an adequate explanation is lacking to the parent, he or she elaborates fantasies toward which she or he responds, the whole complex being outside the awareness of the parents' conscious mentation, only nearing the surface to influence the parents' behavior at later times in their experience with the marital partner and the adopted child.

In relation to the factors revolving around the adoptive parents' thoughts about the natural parent, the adoptor must examine his thoughts and feelings about mothers who give up their children. If the adoptive parent is told a little something about the parent by the agency involved, this information being on the positive side, or even if it is on the negative side, the parent can deal with his feelings about the rejecting parent. However, if the adoptive parent knows nothing at all about the real parent who gave up the child he is raising, his thoughts are free to roam at random, producing fantastic notions which may interfere with later developmental stages as they normally occur in the child. (More will be said about this below.)

### **The Older Adopted Child**

For the older adopted child the psychological work involved prior to his being able to accept the adoptive parents includes his acceptance of his first parents, with all their faults and human frailties and his understandings that he was not responsible for the family's rejecting him.

Next, are the special psychological problems with which the adoptive parent must deal as his child matures. They can be grouped as follows: 1. Problems related to telling the child he is adopted; 2. Problems related to the child's expression of sexual and aggressive impulses; and 3. Problems related to the adolescent period of the adoptee.

### **Child Should Be Told**

Adoption agencies today are recommending that the child be told of his adopted status. Agencies vary in the help they give the parent as to when and how this fact is to be presented to the child but many emphasize using the word "adopted" to the child from an early age. Many of the adopted children seen by the psychiatrist flounder in their development because of the timing or manner or the emotional tone in which this is told the child. One cannot help but wonder whether each parent, if given a chance to talk out and decide this for himself, might arrive at the best solution for him and his child, even though it would not always agree with the facts or the agency's dogmatic advice to each set of parents who receive a baby. It is my speculation that



parents who would easily be able to convey this information to a child whom they had reared for several years might not be able to do so to that same child as a small youngster. It goes without saying that unless the parent has done the work mentioned above in relation to his inability to conceive and the child's parents' inability to raise the child, he will be unable to tell the child about his adopted status at a time or in a manner which will be other than anxiety producing or even detrimental to the child. If the adoptive parent has done his task well, he can then accept the best time and manner of presenting this information to his child.

Our contact with adopted children who have emotional problems leads us to believe that the parent needs to have: 1. resolved his feelings about adoption (as just mentioned), 2. that he needs to know a great deal about the developmental stages of childhood, and 3. that he needs to be an intuitive person, recognizing feelings and empathizing with people. In other words, he needs to be a more qualified parent than he would need to be if raising his own natural born child.

Carl and Helen Doss, in the book, *If You Adopt A Child*, give certain ideas for adoptive parents to use as they tell their child of his adopted state. (The Dosses raised 12 adopted children.) They suggest that the parents introduce the term "adopted" to the child from earliest years ("You are my darling adopted child") doing so when the two are having fun together. The term is then connected with love and pleasure from the parent. If parents have not done their psychological work well, still avoiding the implications of having an adopted child, they frequently reflect unspoken anxiety as they use this word to the child and they frequently choose an inappropriate time to say it. (This can be compared to the parent who has been told to inform their child about sex matters, but has such a basic embarrassed, guilty feeling about sex himself that the child hears both the words and the feeling, thus getting the idea that sex is shameful, the thought which the parent was trying to avoid. According to the Dosses, the intuitive adoptive parent who has done his work well then responds to the child's questions only when he asks further, this meaning, as in other matters, that the child is ready for additional information. Such questions as "Where do babies come from?" which the three or four year old child may ask, can be answered factually with, "From a special place inside the mother's body," as any parent reading the current ladies' magazines will answer today. It is only when the child asks, "Did I grow in your insides?" (usually a year or so later than the previous question) that the adoptive mother can

say, "No, you grew in your first mother's body." The five year old usually comes back with, "Didn't you want your baby to grow inside you?"—not yet recognizing that there is another mother involved—to which the adoptive mother can reply, "Yes, very much, but I was unable to have my baby grow this way, so I got you from the hospital after you grew in another mother's body." Again, the mother answers further questions as they occur. When the child is about seven or eight, he usually has progressed his understanding of life to ask, "Why did my mother give me up?" The mother who does not know and who has done the psychological work previously mentioned can easily answer the child as to her lack of knowledge in this area as well as her conviction that his other mother must have had a very good reason to feel it necessary to give up her child, that it must have been that she felt she could not give the child the love and attention that all children need and that she knew that some other mother could. She may add that it must have been sad for his first mother.

2. In yet another area, adoptive parents are likely to have more than the usual amount of difficulty with their children. This is the area dealing with basic energy, both sexual, aggressive, and antisocial behavior, and the control, or discipline of, such energy. When the child does the usual pre-school age exploration of the differences between the sexes, the adoptive mother may immediately fear that the child is a sex addict. Adoptive parents frequently are over-indulgent, over-permissive, and disinclined to exert effective discipline of their adoptive child. The most difficult adoptive families seen by the psychiatrist are those in which a complementary neurosis between parent and child is present. The child represents the parents' unacceptable, repressed sexual and aggressive drives, thus acting out the "bad" for the family.

3. The psychological problems of the parent of the adolescent adoptee concern fantasies, which, though adequately met by the parent when the child was young, are now reawakened and take on new and different meaning as the adolescent begins to become interested in the opposite sex. The parent must again deal with the fact that he remained barren while his child is now blossoming into a sexual, presumably fertile, being. This can be a basis for jealousy of the child one has raised or a basis of experiencing through the child an event denied the parent. Also, even very mature individuals who feel basically that morals are not inherited may, if not knowing much of the child's natural parent, be afraid that this child may be lacking in judgment related to sexual matters. The parent then may act



in such a manner that his way of handling the ordinary sexual experiences his adolescent has are not helpful and actually tend to cause the child to be unwise.

### **The Adoptee**

Now, to the adoptee. There are special psychological problems the adoptee must deal with in addition to the problems all children face in their normal development. Although previous discussion about the work parents need to do prior to adopting a child and the special problems they have as the adoptive child matures emphasized what the parent must do and how he must do it, it goes without saying that most parents are not altogether successful in this psychological work. Therefore, the adoptive child is able to go no further in handling the special problems related to his adopted state than is the parent able to allow the child to talk about, and therefore, deal with realistically the implications of the relationship between the child and his parents, and between the child and his unknown past.

Again, no matter how well the parent deals with the problems himself, he is unable to keep the adoptive process from producing increased stress on the personality development of the child in a great number of cases. The immature child cannot cope with the knowledge of the rejection by his original parents. According to Clothier, "A deep identification with our forbearers as experienced originally in the mother-child relationship, gives us our most fundamental security. Every adopted child at some point in his development has been deprived of his primitive relationship with his mother. This trauma and the removing of the individual from his racial antecedents lie at the core of what is peculiar to the psychology of the adopted child."

### **Two Achievements Hindered**

Two achievements in ego development of the adopted child are hindered by the fact of his adoption. One is that some children, when told at a young age have difficulty in making object relationships. Their relationships with people then tend to be less close, more superficial, and less meaningful. Again fusing and integration of concepts may be more difficult for some adopted children. The usual child of five or six years of age frequently deals with the mixed feelings he has when frustrated by the parent by the fantasizing that he actually has better parents who love and cherish him more than the ones with whom he must deal everyday. This is called the "princess fantasy." The child who lives with his real parents can have these feelings about

the frustrating parents, being able to see the bad side of their parents contrasted with the good, permissive, and giving side of the same parents. The adoptive child has a chance, however, of splitting the image of his parents, attributing the good elements to one set of parents and the bad to the other. They thus keep the good and bad images diffused, which may lead to problems of ego ideal formation.

The adopted child has to deal with the "why?" of his being given up by the original parents. Fantasies vary during different stages of the child's growth; they may be "my mother gave me up because she wanted a girl" (if the child is a boy) or "my mother didn't want to give me up but someone stole me away," in the younger child; but change when the child is an adolescent to, "my mother was immoral; I was illegitimate."

The adopted child also has fantasies as to what the real parents were like. These take many forms and may occupy a great deal of the child's time and thought. As the child gets older he may develop an over-powering desire to know what the real parent was like. The adolescent may begin to wander aimlessly in search for an indefinable something; he may act like the fantasied absent parent; or he may go to great lengths to obtain information about the real parent, even trying to see the parent if the involved agency will give this information. In response to this some agencies will contact the former mother, asking if the mother would like to gratify the child in this matter. Where this has been done, and the mother agrees to this contact with her child, it is often very disturbing to both. For the real mother, like the adoptive mother, cannot approach the rich fantasies of her which the child has developed through the years. Like the adopted parent who can better give up unreal fantasies about the natural parents if he has some slight amount of good information about the real parent, the adopted child, too, can more realistically deal with his unknown parentage if he has a slight bit of knowledge which is true (such as, "the agency said your family had some musical talent," or "the agency said you come from tall, robust people," etc.).

### **More Maturity**

In conclusion, it seems from the study of the adoptive process, that the adoptive parent needs to be more mature than a physical parent, he needs to know more about himself; he needs to be able to give more love and understanding to a child; and he needs to know more about the developmental stages of childhood than does the natural parent. Then the adoptive parent can help the child with the psychological problems inherent in adjusting to his adopted-



ness just as he helps with other problems. From their common accepted needs (the parent, for a child; the child, for a parent) each can develop a richness of human experience and sharing.

The parent who can best fulfill his role as adoptor must be able and ready to deal with the everyday realities of raising the child of another, having given up his fantasies of having a child of his own heredity, and having resolved his fantasies related to the raising of the child of a parent of unknown heredity and morals.

The child is then best able to deal with the special psychological processes involved in his adopted status. He makes the best solution if he can. Finally, as an adult, he must accept himself as a person with an unknown identity (real parents) and a known, loved, and loving identity (adoptive parents). The child then knows in his mind that he came from one family, but in his heart he knows he belongs in his other family.

In concluding, it should be recognized that the normal psychological problems of adapting to adoption have been obtained or inferred from contact with parents and children who have come to the psychiatrist for help. Additional information from other sources might be most useful and illuminative in learning further about adoptive children: namely 1.) studies of the intrauterine conditions of the natural mothers; and 2.) studies of the adoptive families who do not need psychiatric help for the children involved; and 3.) studies of adoptive families in whom the children are not told of their adopted state, including both families in which the child

never discovers the fact of his adoption and those in which the child inadvertently makes this discovery. And of great interest would be studies of the adult, raised from infancy in an adopted home, and the effects of the adoptive process as he raises his children.

*Medical College of Georgia*

#### Bibliography

1. Amatruda, Catherine S., M.D. and Baldwin, Joseph V., M.D.: "Current Adoption Practices," *Journal of Pediatrics*, 38:1951, 208-212
2. Black, J. A., M.D., and Frederick H. Stone, M.D.: "Medical Aspects of Adoption," *The Lancet*, 1958—Dec.-1272-1275.
3. Doss, Carl and Helen: *If You Adopt a Child*, 1957.
4. DuPriest, Ann E., M.S.: "Problems of Eighteen Adopted Children and Eighteen Natural Children, Jefferson County, Alabama, Mental Health Clinic, Jan. 1955—November 1960" (a study).
5. Eiderson, Eunice, and Levermore, Jean: "Complications in Therapy with Adopted Children," *American Journal of Ortho Psychiatry*, 23 1953, 795-802.
6. Eisenberg, Leon, M.D.: "The Sins of Fathers: Urban Decay and Social Pathology," *American Journal of Ortho Psychiatry*, 1962 (5-17).
7. Grant, Wallace, M.D.: "The Doctor and Adoption," *Pediatrics Clinics of N. A.*, May, 1958, 523-530.
8. Karelitz, Samuel, M.D., Moderator: "Adoption as a National Problem," *Pediatrics*, 20:366-386, 1957.
9. Mayer, O. B., M.D.: "The Physician in Child Adoption," *South Carolina Medical Journal*, 54:1958, 41-44.
10. Wessel, Morris A., M.D.: "The Pediatrician and Adoption," *N. E. J. of Med.*, 262 1960-March 446-450.
11. Rathbun, Constance, M.S.S.; Virgilio, Letitia di, M.S., and Waldfogel, Samuel, Ph.D.: "The Restitutive Process in Children Following Radical Separation from Family and Culture," *American Journal of Orthopsychiatry*, 1958, 28: 408-415.
12. Schechter, M.D.: "Observations on Adopted Children," *Arch. Gen. Psychiatry* 3: 21-32, 1960.
13. Schechter, Marshal D., M.D.; Carlson, Paul V., Ph.D.; James Q. Simmons, III, M.D.; Henry Worh, M.D.: "Emotional Problems in the Adoptee," *Arch. of Gen. Psy.*, Feb. 1964, Vol. 10, pp. 109-118.

## 1965 CALENDAR OF MEETINGS

### State

- August 15-20—The Fifth Southeastern School of Alcohol Studies, The Georgia Center for Continuing Education, Athens.  
May 8-10, 1966—112th Annual Session of the Medical Association of Georgia, Columbus.

### Regional

- August 19-21—18th Annual Postgraduate Obstetric-Pediatric Seminar sponsored by the Children's Bureau, the Maternal and Child Health Services of Georgia, Alabama, South Carolina, Florida and Mississippi, and Medical Associations of the five states, Ramada Inn, Cocoa Beach, Fla.  
August 19-21—Eighth Annual Medical Progress Assembly presented by the Birmingham Academy of Medicine, Parliament House, Birmingham, Ala.

- August 22-27—11th Annual Flying Physicians Association, Deauville Hotel, Miami Beach, Fla.  
September 9-11—American Association of Obstetricians and Gynecologists, Homestead, Hot Springs, Va.  
September 14-17—American Association of Blood Banks, Americana Hotel, Bal Harbour, Fla.  
September 27-28—Tennessee Valley Medical Assembly, Tivoli Theatre, Chattanooga, Tenn.

### National

- September 15, 1965-June 15, 1966—A nine month tutorial program in Cardiology offered by the Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, LaJolla, Calif.  
November 28-December 1—American Medical Association (Clinical Convention), Philadelphia.

# NUTRITIONAL DISEASE IN GEORGIA

F. J. Clune, Jr., Ph.D. and Ira E. Robinson, Ph.D., *Athens*

## ■ A striking decrease in pellagra deaths has occurred in the past two decades.

THE RELATIONSHIP between a given culture and its diseases has long been documented in the literature of social science and medicine. Epidemiology may in part be viewed as more of a social science problem than a medical one. Tuberculosis was a product of the industrial environment of the city; bubonic plague was the consequence of the lack of proper sanitation, and pellagra in the United States, the consequence of dietary deficiency. Pellagra has been a disease characteristic of the southern region of the country. The last of these diseases is the result of the peculiar diet characteristic of the South. The diet was severely lacking in certain essential nutritional elements, niacin for one. Matthews clearly showed in 1929 that the typical diet of the rural family in Georgia was deficient in milk, fresh fruits and vegetables, eggs and meat.<sup>1</sup> Pellagra was of course the direct result of this diet.

### An Epidemic

During the first four decades of this century the deaths from pellagra in the state of Georgia were of such proportions that it might be termed epidemic. Table I shows the deaths from pellagra in Georgia. If we compare these rates with those from other southern states, it becomes readily apparent that they were a peculiar feature of the South. In Georgia they were noticeably higher, in all but one state, and even higher than that in most years (Table I).

As a result of the work of Goldberger and his associates in the 15 years from 1912 to 1927, the cause of pellagra was clearly demonstrated to be

the same as "black tongue" in the dog—that is, a grave deficiency of niacin.<sup>2</sup> The work of Elvehjem and his associates, when coupled with Goldberger's work, showed that massive doses of brewer's yeast (containing large quantities of niacin) eliminated the symptoms of pellagra.<sup>3</sup> As a consequence of these findings, the Georgia Department of Public Health distributed approximately nine tons of brewer's yeast yearly from 1929 to 1962.<sup>4</sup> During the early years of this program, however, while the death rate did decrease, the number of deaths was still far in excess of the rest of the United States (see Table I). This was of course associated with a low level of living for the rural population, but Mississippi had (and still has) a lower level of living for its farm population and yet a much lower number of pellagra deaths. The key difference between these two states was the diet of the two populations. The average Georgia farm family drank one-half as much milk as did the Mississippians.<sup>1</sup>

In other words, the chief difference during the period prior to World War II was the dietary differences between the Georgia (and Southern) population and that of the rest of the country.

### A Documentation

The problem of the Southern diet and its source was documented in the works of Rupert Vance, as shown in his book *Human Geography of the South*.<sup>5</sup> The diet of the region was fixed on the South not by poverty alone (in fact we would venture to guess not by poverty at all!) but by the cultural character-

TABLE I.  
Deaths from Pellagra by Area and Selected States: 1920-1955\*

	1920	1925	1930	1935	1940	1945	1950	1955
New England . . . . .	21	21	24	29	10	7	2	3
Middle Atlantic . . . . .	27	38	42	45	45	24	4	3
E. North Central . . . . .	22	28	60	59	52	17	14	—
W. North Central . . . . .	35	39	45	27	33	19	2	5
South Atlantic . . . . .	944	1,066	3,002	1,394	727	292	93	41
Georgia . . . . .	—	76	709	367	253	107	37	23
E. South Central . . . . .	925	1,455	1,745	770	645	249	75	22
Mississippi . . . . .	558	570	572	224	169	56	16	5
Mountain . . . . .	1	15	65	18	33	10	6	—
Pacific . . . . .	17	53	60	100	49	20	3	1

\*United States Vital Statistics, United States Bureau of Census, Department of Commerce (Washington, D.C.: 1920, 1925, 1930, 1935, 1940, 1945, 1950, 1955).



istics of the region. The diet was the result of a frontier economy; corn, a staple of the Indian, became a staple of the white man but the fresh lean wild meat gradually was replaced by the pig. The salt pork diet became fixed upon the region.<sup>5</sup>

With the change from a frontier to a rural economy the diet remained. "The heritage of diet was carried on in the rural culture with both the growth and purchase of food determined by likes and dislikes that firmly entrenched a diet deficient in all but fats and sweets."<sup>5</sup> All of this was true in spite of the fact that the region could easily grow fruits, vegetables and livestock which would have eliminated the disease.

Changes After War

The real changes in the pellagra death rate came about after the Second World War. By 1960 they were almost non-existent. What were the causes of the precipitate drop from 1945 to today? Several changes in the structure of Georgian society were occurring: (1) it was urbanizing, (2) the agricultural patterns were changing; and (3) the effects of the educational effort to improve the diet were beginning to be felt.

To take these in order—the number of farm operators in the state of Georgia decreased from 216,000 in 1940 to 106,000 in 1959, a drop of more than 50%. At the same time the urban population increased to 55% of the total;<sup>6,7</sup> there was a rise in the average age of these farm operators from 45.8 years old in 1940 to 51 in 1959.

The second change in agriculture was even more dramatic. After the war, the old pattern—cotton, tobacco, and corn, began changing to the present three "P's"—Pulp, Poultry and Pasture. Even more important is the real diversification of farming in the state, with commercial vegetables and beef growing in importance and king cotton declining. This has also meant a change in the diet of the population. As one agriculture extension worker has said, "You can't tell the farmers in the supermarket from the townspeople anymore."

Looking at the death rates in Georgia we still find that they are in the rural areas, but with a decreasing farm population the deaths also came down.

If we look at Table II it becomes apparent that there is a much higher proportion of deaths for pellagra in the rural areas than in the metropolitan and urban regions (and we suspect that a large percentage of those in the urban areas are migrants from the country). If, as might be expected, the deaths were distributed randomly, the number of deaths in the rural areas should be nine. Actually there are 21; 2½ times the expected frequency.

TABLE II.  
Deaths from Pellagra by Rural, Urban Location: 1955\*

Area	Number of Deaths	Per Cent	Per Cent of Total Pop. in Category
Rural . . . . .	21	80.8	45.00
Urban . . . . .	5	19.2	55.00

\*State of Georgia, Department of Public Health Statistics, Personal Communication.

The last point is the effect of education on diet. From the medical standpoint perhaps the most interesting, it shows the median age at death from pellagra from 1935 to 1955: the median age at death in 1935 was approximately 52, twenty years later in 1955 the median age had risen to 72. Of particular significance is that there were no reported deaths from the age groups below 25. This is the group who received the major educative efforts in the public school system.

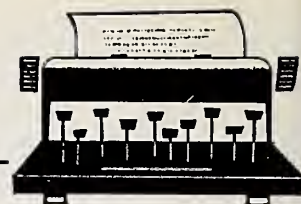
Great Changes

In summarizing, it is apparent that the striking decrease in pellagra deaths is the consequence of the great social and cultural changes which have taken place in the state of Georgia and the South in general. But, we would also like to point out that pellagra has probably not completely disappeared. From the standpoint of the practice of medicine in the South one cannot as yet eliminate pellagra as a potential and actual disease. (In fact, in the North, marginal cases may go unrecognized from a lack of awareness). The doctor in the rural areas should probably expect to see a few cases, particularly in the older population, and the practitioner in the urban areas must be alert for it as a possibility in that part of the population which has recently migrated into the city.

Departments of Sociology and Anthropology, University of Georgia

Bibliography

1. Mathews, Susan J.: "Food Habits of Georgia Rural People," *Georgia Experiment Station Bulletin*, No. 159, (1929), pp. 15-17.  
2. Goldberger, Joseph; Waring, C. H.; Willets, David G.: "The Prevention of Pellagra." A test of diet among institutional inmates, U. S. Public Health Rep. 30, (1915), pp. 3117-3131.  
3. Elvehjem, C. A.; Madden, Robert J.; Strong, F. M., and Woolley, D. W.: *Relation of Nicotinic Acid and Nicotinic Acid Amide to Canine Black Tongue*. (Letter to editor.) *Journal of American Chemical Society*, Vol. 59, pp. 1767-1768.  
4. Personal communication from Dr. Eleanor Petrie, Department of Nutrition Services, Georgia Department of Public Health.  
5. Rupert Vance: *Human Geography of the South* (Durham, North Carolina: University of North Carolina Press, 1932), pp. 411-441.  
6. U. S. Census of Agriculture, *Counties*, Part 28, Volume 1.  
7. United States Vital Statistics, United States Bureau of Census, Department of Commerce (Washington, D. C.: 1963).



## Welcome Aboard

IT IS with genuine pleasure that the Editorial Staff of the Journal welcomes Lakeside Laboratories to our advertising pages. We are certain that the ad-

vantageous exposure of their ethical product message to our readers will prove beneficial to both the producer and the prescriber.

Again, Welcome aboard!

## The Use of Antimetabolites in "Connective Tissue" And "Autoimmune Diseases"

THE MANAGEMENT of "connective tissue" diseases and so-called "autoimmune diseases" is fraught with difficulties. Response is either lacking or incomplete in many instances and the prolonged treatment with corticosteroids required in some cases may provide serious and sometimes irreversible consequences.

A group of potent though dangerous agents has been used in connective tissue diseases for about five years with partial to complete success. These are the immunosuppressive drugs, the antimetabolites purinethol (6-Mercaptopurine), 6-Thioguanine and azathioprine (Imuran).

Schwartz, Stack and Dameshek<sup>1</sup> demonstrated suppression of antibody production by purinethol in 1958. A number of investigators reported in 1960-61 on homograft survival prolongation by these drugs.<sup>2</sup> Dameshek and Schwartz<sup>3</sup> published in 1960 encouraging results of treatment with thioguanine or purinethol in six patients with hemolytic anemia and eight patients with lupus some of whom were also given corticosteroids. In 1962, Eisen et al<sup>4</sup> treated two patients with lupus, one with scleroderma and one with atopic dermatitis with thioguanine alone. Results were perhaps better than with corticosteroids.

The exact mechanism whereby these agents act is uncertain. While antibody suppression may be a factor in some cases treated with these drugs, a fall in gamma globulin, suppression of secondary immune responses, and a cellular immunity may occur.<sup>3</sup>

More recent results indicate that some effects may be achieved with antimetabolites plus corticosteroids which are not attainable with either alone. Michael et al<sup>5</sup> did serial needle biopsies in 81 patients with renal disease. Fluorescent antibody studies and electron microscopy showed that 18 patients with idiopathic nephrotic syndrome with normal light microscopy had no gamma globulin or B<sub>1</sub> on the glomerular membrane. Sixteen of these had complete remissions and cessation of proteinuria after corticosteroid therapy. Five patients with definite light microscopy lesions showed gamma globulin and B<sub>1</sub> on the glomerular basement membrane and were resistant to corticosteroid therapy. Three patients with disseminated lupus, chronic glomerulonephritis, and subacute nephritis with gamma globulin and B<sub>1</sub> deposits on the glomerular basement membrane were treated with high doses of Imuran (azathioprine) and high dosage Prednisone. After one month of therapy all deposits cleared in the nephrotic patients and a striking reduction in fluorescence was seen in the lupus patients glomerular basement membrane. These changes were accompanied by marked clinical improvement with reduction of blood urea nitrogen to normal and increased renal function and serum complement.

We have seen one patient with proven periarteritis nodosa with recurrent ten-day episodes of high fever and hemorrhagic painful nodular lesions along



the vessels which would not respond to daily doses of 80 mg. of Prednisone. Supplementation with purinethol (6M-P) stopped the exacerbations and signs of active disease. We have also used combined therapy in patients with lupus to permit a reduction in corticosteroid dosage to a "sub-cushingoid level."

Careful Daily Follow-Up

The use of antimetabolites must be accompanied by careful daily follow-up of the leukocyte count until the dose is stabilized and they probably should not go more than a week without a count after this. Less frequent checks of the blood platelets and erythrocyte counts should be made. One of our patients developed loss of appetite and was found to have bromosulphthalein retention. Resumption later at a lower dosage permitted a return to normal.

While some authorities believe that the drugs must be pushed to the point of leukopenia to achieve full

immunosuppression, others seem to obtain definite results with more modest doses.

Arthur J. Merrill, M.D.  
35 Fourth Street, N.E.  
Atlanta, Georgia 30308

BIBLIOGRAPHY

1. Schwartz, R.; Stack, J., and Dameshek, W.: Effect of 6-Mercaptopurine on Antibody Production, *Proc. Soc. Exp. Biol. and Med.*, 99:64, 1958.
2. Calne, R. Y.: Inhibition of the Rejection of Renal Homografts in Dogs by Purine Analogs; *Transplantation Bulletin* 28:65, 1961.
3. Dameshek, W. and Schwartz, A.: The Treatment of Certain "Autoimmune" Diseases with Antimetabolites, *Trans. Assoc. Am. Phys.* 73:113, 1960.
4. Eisen, B.; Dennis, D. J., and Crosby, W. H.: Thio-guanine Therapy, Systemic Lupus Erythematosus, Atopic Dermatitis and Other Non-Malignant Diseases, *J.A.M.A.* 179:789, 1962.
5. Michael, A. F.; Drummong, K. N.; Good, R. A., and Vernier, R. L.—Immunoglobulins: Clarification of Their Significance in Renal Disease and Demonstration of Response to Immunosuppressive Therapy, *Journal of Clinical Investigation* 43:1291, 1964.

Area-Wide Hospital Planning — What Is It?

A RELATIVELY new concept in the provision of health care has been introduced in Georgia with the advent of Area-Wide Hospital Planning Councils, especially for metropolitan centers now and non-urban areas later. AMA devoted a two-day meeting to this subject and MAG will hold a similar meeting in the near future. Let's take a look at the "why and wherefore" of this type organization: its purpose, composition and activity.

Purpose

The proposed objectives of these new Area-Wide Councils are to: (1) Plan the efficient and economical development of hospitals in accordance with the needs and available resources of the community; (2) Review proposals of individual hospitals for major capital expenditures; (3) Co-ordinate the services of hospitals, public health, and related health and welfare agencies; (4) Provide consultation in planning for improved health services and financial economy of hospitals and related services; (5) Provide means for a closer correla-

tion of interest of hospitals and medical profession; and (6) Interpret and inform the community of the work of the Council, the various health services in the community and the need for community interest and support of health services.

Organization

Area-wide Planning Councils may be a voluntary or a quasi-governmental type organization with a charter as a non-profit corporation or by joint resolution of local governmental agencies. The Council may be a confederation of organizations or a membership-type organization with a self-nominating Board.

Representation

The Council should be broadly representative of the geographic planning area including direct representation or official endorsement from: (1) Organized medicine; (2) Governing Boards of hospitals and other health care facilities; (3) Local Boards of Public Health; (4) The business community; and (5) The general public as the consumer.

### Jurisdiction and Scope

The Council must define the geographic area of jurisdiction and exercise a planning service for a logical area. The Council should indicate a willingness and intent to plan for hospital and related facilities including those for which tax grant-in-aids monies is available for support.

### Activity and Staff

Council activity should be financed in a voluntary way with a financial program for the continuous support of the Council. The Council should provide for a competent Council Director and full or part-time staff under the direct supervision of an Executive Committee of the Council.

### Relationship to State Health Department

The primary role of the State Health Department is: (1) To encourage the formation of area-wide hospital planning Councils in the State; (2) To provide consultation in the formation, operation and financial support (under the Hill-Harris Amendment—1964) to those Councils that meet U. S. Public Health Service and State Agency standards. In geographic areas with approved Councils, the State Department of Health will require applicants for Hill-Burton grants to have the proposed project reviewed and endorsed by such Councils prior to grant approvals.

### Georgia Councils

Currently, the "Health and Hospital Planning Council of Metropolitan Savannah, Inc.," is organized and staffed as an area-wide planning agency. This Council has received a grant through the amended Hill-Burton (Hill-Harris Amendment—1964) for the operation of its planning activities.

The "Community Council of Atlanta Area, Inc.," has made a similar application for area-wide health facility planning through the State Health Department for Public Health Service grant funds and this application is now pending.

Other Councils organized but not staffed to date: Albany ("Albany-Dougherty County Hospital Planning Council"); Athens ("Northeast Georgia Medical Services Council"); Augusta ("Health and Hospital Planning Council"); Macon ("Middle Georgia Health Planning Council, Inc."); and Columbus ("Columbus Area Health Planning Council, Inc."). These Councils have elected officers and have organized leadership to represent a geographical area in planning health facilities.

### Conclusion

It is obvious that existing and future area-wide hospital planning Councils will be increasingly concerned with the areas they represent in hospitals and related facilities. This activity, as undertaken by the Councils, can have a beneficial effect on improved patient care—or otherwise. Paramount to the success of these Councils is participation in all Council activity by organized medicine. County medical societies can play a vital role in the success of Area-wide Hospital Planning Councils by seeking to serve on these Councils because provision for physician membership is clearly made.

The Medical Association of Georgia House of Delegates meeting May 4, 1965, requested that physicians serve on each of these Councils—and it is now up to each County Medical Society to carry out this MAG action by seeing that such representation is gained and responsibly fulfilled in metropolitan areas. In addition to physician membership on such Councils, the interest of the medical society is a necessary ingredient for successful Council planning.

## AFTER MEDICARE, What?

ORGANIZED labor's monthly magazine, *Agenda*, recently intoned its readers with the question: After Medicare, what? Licking its chops over what it has good reason to believe is the beginning of full-blown socialized medicine in this country, *Agenda* systematically outlined the complete dissection of the medical profession on a step-by-step basis to span the next few years of pot-boiling political and legislative activity.

After Medicare, what? Organized labor asked the question and it is up to the medical profession to supply the answer. One thing is certain, so long as a labor dominated Congress, composed as it presently is, remains in office, the slow but certain domination of the medical profession by Government will proceed with only minor interruptions. If the trend is to be halted and reversed, as indeed it must be, then a



proper balance has to be restored in the Congress. In short, those whose first allegiance is to organized political blocs, and not to the people, must be turned out of office. Those who have earned the label "rubber stamp" by consistently supporting the Administration, the labor unions, the party, or any other regimented entity, to the exclusion of people and the best interest of the people, must not be returned to Washington following the '66' Congressional elections. Obviously, this is easier said than done. But it can be done, and be done it will.

### **To Accomplish the Objective**

To accomplish this objective the wheels were set in motion at a mid-May meeting of the American Medical Political Action Committee in Washington, D. C. This conference was attended by five or more representatives from every state in the Union, including Hawaii and Alaska. The cold, hard facts of political reality were laid on the line as the exacting dimensions of the job to be done were spelled out in meticulous detail. As a parade of sophisticated political experts made their presentations to the assembled

group, it was clear that AMPAC had shed its amateur standing. They are ready to stand toe-to-toe with COPE (organized labor's political arm) or any other group similarly inclined.

After Medicare, what? The answer seems simple. After Medicare comes the 1966 Congressional elections and it seems pretty obvious, even this far in advance, that common sense must be returned to Washington. AMPAC and its first cousin GaMPAC have the know-how to do this job. We have the machinery and the potential for adequate financing. The only element about which there is any concern is, do we have the desire? Are we willing to make the fight, or do we still believe that it's really somebody else's job? Are any of us so comfortable in our present position, that through apathy or an attitude of non-involvement, we would jeopardize the future of the profession—or more importantly, the future of our children? Abraham Lincoln said, "To sin by silence when they should protest makes cowards of men." How will you answer the question: After Medicare, what?

## **MAG 1965 on Relative Value Study**

THE MEDICAL ASSOCIATION of Georgia House of Delegates meeting May 4, 1965, considered and acted upon a report of the Association Council and Relative Value Study Subcommittee as it concerned proposed Relative Value Studies.

For information and clarification, the MAG House adopted the following action on this subject:

"The MAG House of Delegates commends the Relative Value Subcommittee for the amount of work done in preparing the Relative Value Schedule and hereby creates a negotiating committee to be composed of the duly elected negotiating representatives of all the specialty and subspecialty groups (this is intended to include the Georgia Academy of General Practice). These representatives to be elected by their specialty or subspecialty group and to have the authority to negotiate with third parties a fee schedule for

their specialty or subspecialty—such fee schedules being subject to final approval by Council of MAG. To aid in this committee deliberation, the House of Delegates refers the current Relative Value Schedule (California—1964) and makes mandatory the review of this Relative Value Schedule every three years, and makes mandatory the review of a specialty or subspecialty's Relative Value Schedule upon receipt of a petition signed by more than 50% of the participating members of a specialty or subspecialty. This is of sufficient importance and complexity to warrant that at the Delegates meeting in 1966, this matter be referred to a special Reference Committee to which no other business is assigned."

This action of the House has been referred to MAG Council for implementation in carrying out the creation of the aforementioned committee.

## LOMOTIL *Pharmacologic Activity*

The significant pharmacologic actions of Lomotil are summarized as follows:

Evidence indicates that Lomotil acts directly on the intestinal musculature to inhibit excess peristalsis.

Lomotil is not known to inhibit nonpropulsive intestinal movements.

Roentgenograms demonstrate that this activity occurs within two hours after oral administration and persists for at least six hours.

Comparative studies in the rat show Lomotil to be more effective in inhibiting fecal excretion than either codeine or morphine.

Analgesic, anticholinergic, mydriatic and gastric secretory effects have not been significant.

Reduction of propulsive motility with Lomotil relieves spasm and cramping, allows physiologic absorption of fluid and reduces frequency of evacuations to provide prompt, symptomatic control of virtually all diarrheas.

# LOMOTIL®

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride .....2.5 mg.

(Warning: May be habit forming)

atropine sulfate .....0.025 mg.

## tablets • liquid



**slows propulsion**



**relieves distress**



**stops diarrhea**



*Precautions:* Lomotil is an exempt narcotic preparation of very low addictive potential: more than three million prescriptions have now been written for Lomotil. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

*Side Effects:* Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

*Dosage:* For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses*, until diarrhea is controlled, are:

**Children:**

- 3 to 6 months—3 mg. ( $\frac{1}{2}$  tsp.\* t.i.d.)
- 6 to 12 months—4 mg. ( $\frac{1}{2}$  tsp. q.i.d.)
- 1 to 2 years—5 mg. ( $\frac{1}{2}$  tsp. 5 times daily)
- 2 to 5 years—6 mg. (1 tsp. t.i.d.)
- 5 to 8 years—8 mg. (1 tsp. q.i.d.)
- 8 to 12 years—10 mg. (1 tsp. 5 times daily)

**Adults:**

- 20 mg. (2 tsp. 5 times daily or
- 2 tablets 4 times daily)

*\*Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdose.

**SEARLE**

*Research in the  
Service of Medicine*



## **"SITTING IN THE CAT-BIRD SEAT"**

**W**HEN the thought occurred to me to write a letter using the above title, I must confess that I was thinking in terms of the "Cat-Bird Seat" being like the "Driver's Seat." It didn't take too long, though, to learn that the connotation of being in the "Cat-Bird Seat" is more like that of "sitting pretty."

Before I assumed the office of President I was well aware of the fact that the office entailed many responsibilities and would call for many decisions and that such being true I would not be likely to be "sitting pretty."

With the things which are going on in Washington, it is realized that during the year 1965-66, the above is probably true more than at anytime since the days of the Talmadge Hospital "hassle." Before the first month was over the truth of the foregoing was becoming evident.

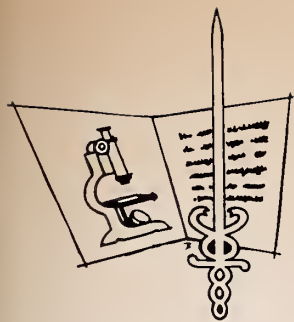
During the several preceding years, it has been real pleasant to sit around the table with Council or the Executive Committee and participate in discussions to shape up policy, but feeling that many times in a tight spot it would be up to the President to make a "lonely" decision. In many instances the President does have to make such a decision, but thank God and the moulders of our Constitution and By-Laws for the Executive Committee.

Almost always if a decision is of sufficient importance it fortunately is usually possible to set up a telephone conference meeting of the Executive Committee. On such occasions, the "ball can be batted around" and several heads thereby participate in the decision. In those other situations when a "lonesome" decision must be made—an honest effort will be made to make it the right one. If a mistake is made, try to remember that it will be a mistake of the head and not the heart.

You may have noticed that I seem to like to quote Dr. Donovan Ward and he has had some excellent quotable material—so I will do it once again. He noted recently that the Pennsylvania Dutch like to say: "so soon we grow old and so late we grow smart." I would like very much to find a way to bring about the transposition of those events—then I would have been smart for a long time and probably being in the "Driver's Seat" would be like being in the "Cat-Bird Seat" and would really be a breeze. Not only that—just think—to top it off, I would still be youthful!!!

*George H. Alexander, M.D.*  
*President, Medical Association of Georgia*





### REGIONAL PROGRAM OF THE AMERICAN COLLEGE OF SURGEONS COMMITTEE ON CANCER

Hoke Wammock, M.D.,\* *LaGrange*

**I**N THE LAST fifty years there has been phenomenal progress in cancer control, and the plans for the future lend inspiration and hope for eventual control of this devastating disease. Let's briefly review the past and take a look into the future.

#### The Inception

The Cancer Control Program of the American College of Surgeons had its inception at the Third Clinical Congress of Surgeons of North America, November, 1912, when a "Cancer Campaign Committee," ancestor of the present Committee on Cancer, was appointed. This Committee was headed by Dr. Thomas S. Cullen of Baltimore.

In 1922 the Board of Regents established a committee on treatment of malignant diseases with radium and x-ray with Dr. Robert B. Greenough of Boston serving as Chairman.

In 1929 the Committee was re-designated, "The Committee on Treatment of Malignant Diseases."

In 1939 the name was changed to the Committee on Cancer, the name it bears today.

The prime mission of the Cancer Control Program was education, not only for the Medical Profession, but for the public as well.

In 1913 the first publication appeared in the *Ladies Home Journal*. It was entitled, "What Can We Do About Cancer?" by Samuel Hopkins Adams.

#### The Milestones

It is significant enough that in 1913 the American Cancer Society was organized to disseminate information to the public and profession on cancer. Thus, two organizations, The American Cancer Society, a volunteer group, and the American College of Surgeons, a scientific body, joined forces in cancer control over a half century ago.

In 1929 the Board of Regents of the College of Surgeons authorized the establishment of a register for bone sarcomas, under the direction of Dr. Bowman C. Crowell. In 1953 this was transferred to the Armed Forces Institute of Pathology.

Another important milestone was reached in 1927 when the American Cancer Society appointed Drs. Greenough, James Ewing and John C. A. Gersher of New York, "To Report On The Best Methods Of Improving The Service To the Cancer Patients." Based on their findings, entitled, "The Medical Service Available For Cancer Patients in The United States—Suggestions For Improvement," is the College's present program for survey and approval of cancer facilities in the United States and Canada.

Accepting the American Cancer Society's invitation in 1929 to make "present day knowledge of cancer immediately available to the patient in a most effective way through the supervision of organization and administration of cancer clinics in approved hospitals throughout the continent," the College in 1939 laid down the rules and regulations entitled, "Organization of Service for the Diagnosis and Treatment of Cancer—a *Minimum Standard*." These rules are in force today.

The survey of the cancer clinics began in 1931. The first list of "Cancer Clinics Approved" was published in 1933, and they numbered 140. Today, thirty years later, 1000 cancer programs in the U.S. and Canada are approved. The requirements for approval today are higher and more stringent.

#### To Improve Care

In 1961 the Committee on Cancer of the College of Surgeons began its Regionalization Program, perhaps one of the most ambitious projects of all times. Dr. R. Lee Clark describes the program as "evolutionary, and not revolutionary." The purpose is to improve the care of the cancer patient. In their

\*Liaison Fellow, American College of Surgeons, Georgia Chapter.

search to achieve this improvement, the Committee on Cancer has developed the concept of the Liaison Fellow. A Liaison Fellow is appointed for each state. He is to act as an agent between the Committee on Cancer of the College and other organizations and agencies that are interested in cancer control. The Liaison Fellow serves as an advisor, or counsellor to the various cancer programs in his area. The purpose is to coordinate the activities of all agencies concerned with cancer control, and to assist the various tumor clinics in planning their programs. He will visit and advise, and assist in developing the programs of the various clinics throughout his area.

The "Regionalization Program" is derived from the division of the United States and Canada into 14 sections with a Section Chief as a consultant.

Participating and coordinating in the "Regionalization Program," in addition to the College of Surgeons, is the College of Radiology, The College of Physicians, The College of Pathology, The American Cancer Society, and the United States Public Health Service (State Service). All these organizations are working toward a common goal; to improve the care of the cancer patient.

*West Georgia Cancer Clinic*

---

*Approved by the Professional Education Committee, Georgia Division, ACS.*

## **APPLICATIONS FOR RESEARCH SUPPORT IN 1966 AVAILABLE FROM AMERICAN HEART ASSOCIATION**

The American Heart Association is now accepting applications from research investigators for support of studies to be conducted during the fiscal year beginning July 1, 1966.

### **Deadline**

September 15, 1965, is the deadline for submitting applications for Established Investigatorships and Advanced Research Fellowships.

Applications for Grants-in-Aid should be submitted by November 1, 1965. Grants-in-Aid are made to experienced investigators to help underwrite the costs of specified projects, such as equipment, technical assistance and supplies.

### **Proven Ability**

*Established Investigatorships*, with a stipend of \$11,000 and increments of \$1,000 yearly, are awarded for five years to scientists of proven ability who have developed in their research careers to the point where they are independent investigators. An additional \$1,000 is given as a grant to the investigator's institution.

*Advanced Research Fellowships* are awarded for one or two year periods to postdoctoral applicants who have at least one year of research training and experience at time of application but are not clearly qualified to conduct their own independent research. Base sti-

pends begin at \$6,500, plus dependency allowances and yearly increments. An additional \$500 grant is made to the investigator's department.

The Association also appoints a limited number of investigators of unusual capacity and widely recognized accomplishment as Career Investigators, assuring them of financial support throughout their careers. These awards are made by the Association's Board of Directors on recommendation of the national Research Committee and *not by application*.

### **Local Heart Association**

Research Fellowships, to provide training under experienced guidance for young scientists with doctoral degrees, are no longer being awarded by the American Heart Association. Instead, application for such support should be made to local Heart Associations.

The Association is continuing its program of Emergency Grants. These are made for one-year periods on a non-renewable basis.

### **For Information**

Further information and application forms for research awards may be obtained from the Director of Research, American Heart Association, 44 East 23rd Street, N. Y., N. Y. 10010





## DIGITALIS INTOXICATION

C. D. Cabaniss, M.D., *Atlanta*

**D**IGITALIS INTOXICATION is a major clinical problem. Reports indicate that from 7% to 15% of patients receiving digitalis become intoxicated. In one study, 11% of patients intoxicated died with death directly attributable to digitalis.

### Manifestations

1. Extra-cardiac: These signs of intoxication may occur alone but more commonly with cardiotoxicity.

A) The most common are gastrointestinal; anorexia, nausea and vomiting; diarrhea is uncommon. The gastrointestinal effects are centrally mediated and occur whether given orally or parenterally and should be differentiated from the acute gastrointestinal irritation following large doses of digitalis leaf.

Low grade anorexia may result in significant weight loss before the cause is recognized.

B) Neurological: Most common are disorders of visual perception—yellow, green or vari-colored hazes are noted over objects. Blurring, flickering and “snow storm” visual sensations are reported.

Neuropsychiatric findings from neuralgic pain to frank psychosis are claimed but difficult to document.

2. Cardiac: The occurrence of arrhythmia is most often the cause of fatal digitalis intoxication. The clinical impression that arrhythmia may be the first and sometimes only sign of intoxication, with purified glycosides in current use, has recently been confirmed.

Several of these arrhythmias have normal rate and rhythm by auscultation and render frequent electrocardiographic observation mandatory.

Any arrhythmia may occur, but only the most frequent and significant will be mentioned.

Ventricular extra systoles occurring frequently, multifocally, or in bigeminy are most frequent.

Ventricular extra systoles, Wenckebach phenomenon, AV dissociation and nodal rhythm comprised 78% of the total in a recent study of digitalis induced arrhythmias.

Although less frequent paroxysmal atrial tachycardia with block is highly specific and a serious arrhythmia.

Ventricular tachycardia requires immediate ac-

tion and should always raise suspicion of digitalis excess.

### Contributing Factors

A) Advanced age: Although difficult to prove statistically, elderly patients seem more susceptible to intoxication.

B) Advanced heart disease: Unfortunately as myocardial function worsens, therapeutic to toxic ratio narrows.

C) Concomitant disease: Patients with liver disease, pulmonary disease, renal disease and myxedema are high risks for digitalis toxicity for varying reasons.

D) Potassium depletion: Diuretics, diarrhea, hemodialysis, vomiting and diabetic acidosis may reduce body potassium and result in intoxication in a previously stable patient. Serum potassium cannot be relied upon as a guide as it may not reflect intracellular or total body potassium.

E) Lack of understanding of therapeutic goals: For example, an ill-advised attempt to “slow the rate” of a compensatory sinus tachycardia in a patient with myocardial infarction unable to raise stroke volume.

F) Misuse of drug: For example, single dose parenteral digitalization of a patient who could await oral digitalization.

### Treatment

In mild cases, withdrawal of digitalis may suffice. Precipitating factors should be corrected when possible.

Oral and/or intravenous potassium chloride remains the treatment of choice in most cases. Potassium gluconate or triplex are inadequate substitutes. Caution must be used in the presence of renal insufficiency or spironolactone administration.

Procaine amide may be useful orally or intravenously when potassium has failed or can't be used.

Sodium EDTA through chelation of ionized calcium ions may reverse arrhythmias but is transient and has unpleasant side effects.

478 Peachtree Street, N.E.

*Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.*



## ADVANTAGES OF PARTNERSHIP

John L. Moore, Jr., *Atlanta*

**S**HOULD the three physicians sharing offices and secretarial services be partners?

Should the single practitioner consider bringing a younger man in as his partner?

Should three obstetricians, tired of constant night calls, form a partnership and rotate night calls?

These and similar questions which will occur to the readers of the Legal Page suggest the desirability of summarizing some of the advantages and disadvantages of partnership.

The writer of this page finds it a great comfort and pleasure to practice law in a "group" much larger than physicians generally form in this state. In the practice of law it is convenient to have a large office composed of men who specialize but who as a group offer general services. Why do doctors not form such groups? The principal reason is probably that doctors, even young ones just starting practice, can make it alone financially. By and large, this is not true with young lawyers.

But the first point to be made is that group practice of a profession can offer the following advantages:

- (1) Sharing of responsibility and the opportunity to discuss the difficult case;
- (2) Sharing of the caseload so that all members of the group can have some weekends, some nights off, and some vacations;
- (3) Leveling of income even though there is illness or vacations are taken.

The partnership, even if composed of only two partners, can plan important retirement benefits not otherwise available to the single practitioner. Except in the unlikely event of death or retirement of both partners at the same time, there will be a continuing office providing services to patients. The percentage of collection of accounts receivable will be appreciably higher than if the sole practitioner notifies his patients of his retirement and their need to find another physician.

The remaining partner can usually pay the retiring partner some amount over a period of time to purchase his interest in capital items and ac-

counts receivable. By a study of the graduated income tax rates, it is easy to see that perfectly legitimate deferring of the amounts payable to the retiring partner can net him more than a collection of all outstanding accounts receivable in one fiscal year.

By the purchase of life insurance and by building up investments the partnership can fund payments to the estate of a deceased partner if he dies in harness. Again, there are tax breaks available.

If the result of group practice is to afford patients whenever needed a man who is then available and reasonably fresh, the patients' health will be secured. Further, the continuing office can provide the same services for generations without patients having to worry about transferring medical records to a new physician on the death or retirement of the sole practitioner.

The partnership, no matter how large, keeps one set of books, prepares and files one office income tax return to the United States and state governments, uses one set of uniform billheads, and maintains one bank account. While these economies may not be overwhelming in economic value, they can be substantial in the saving of the overall professional time spent on bookkeeping details.

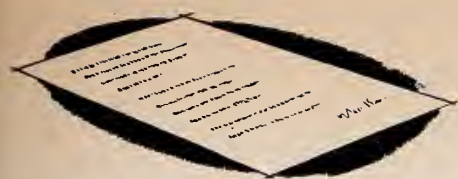
You are responsible for every professional or business act of your partner while he is acting in the practice of the profession or on the business of the partnership. Partnership with another in whom you do not have the highest confidence on the personal and professional basis can be downright unpleasant. It can also be disastrous financially.

Partnership involves the closest daily contact. The personalities and objectives of the partners must be compatible. Absent compatibility, partners who have fallen apart can be as unpleasant to each other as the partners to a domestic relations squabble.

*Suite 1220  
C. & S. Bank Bldg.*

Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.





## ABSTRACTS BY GEORGIA AUTHORS

Sprawls, Perry, Jr., M.S.; William B. Miller, Jr., B.S.; and William D. Logan, Jr., M.D., Emory University Clinic, Atlanta 22, Georgia, "Observation of Electromagnetic Signals from Implantable Pacemakers," J. Thoracic Surg. 49:748-751(May)65.

Battery-controlled implanted cardiac pacemakers by necessity have a limited functional duration. Some have ceased functioning earlier than anticipated due to various reasons, including battery failure, broken electrodes, or increased resistance around the ends of the electrodes.

It has become apparent that a simple method of determining the exact cause of malfunction would be desirable. All Pacemakers produce electromagnetic signals with each discharge, and these can be observed and recorded without making physical contact with the patient.

These signals have been recorded from various aspects of the Pacemakers as an effort to aid in the problem of determining the site of malfunction. Further classification of these signals as related to various Pacemakers and in clinical situations seems indicated.

Turner, Corbett H., M.D., 1317 Clifton Road, N.E., Atlanta, Georgia, "An Approach Toward Well Baby Care During the First Months," J. Pediat. 66:838-843(May)65.

Well baby counseling during the first months should aim at helping parents learn from the infant how to best nurture it. The pediatrician can do this by teaching parents to observe the infant instead of looking for instructions. The physiological variability of infants and the increased confidence engendered in mothers make this approach preferable. Inability of the mother to respond to this type of counseling is evidence of illness of the infant or a problem in mothering. This approach gives mothers who can be sensitive to this baby an opportunity to utilize this capacity, thus minimizing the number who must be given detailed instructions.

Turner, Corbett H., M.D., 1317 Clifton Road, N.E., Atlanta 22, Georgia, "Some Problems in Mothering Encountered During Well Baby Counseling," South. M.J. 58:639-642(May)65.

Well baby counseling during the first months should teach the mother to use her own observations as the basis of most decisions regarding the care of the infant. Inability of the mother to do this is evidence of a problem in mothering. Sources of problems are: cultural attitudes; social, economic, or marital circumstances; distorted perceptions of the baby; or personality disabilities of the mother. Many of these problems can be handled by a pediatrician who is interested in giving his attention to these issues.

Fine, Robert M., M.D., and Harold George Scott, Ph.D., 739 Decatur

Federal Building, Decatur, Georgia, "Straw Itch Mite Dermatitis Caused by *Pyemotes Ventricosus*," South. M.J. 58:416-420(April)65.

Since 1961 nineteen additional cases of straw itch mite dermatitis caused by *Pyemotes ventricosus* were investigated in DeKalb County, Georgia. A parasitic relationship between the mite and common furniture beetle (*Anobium punctatum*) was demonstrated (as has been previously reported). The afflicted beetles were found to be infesting the flooring of the patients' houses. Unusually fine examples of patients' co-operation which led to the discovery of the mite and their host are documented. The clinical features of straw itch mite dermatitis are described and compared with those of the five most common groups of biting arthropods: chiggers, biting flies, fleas, bed bugs and lice. The importance of directing the patients' search for the mite and its host is emphasized.

Yeh, Thomas J., M.D.; George Batayias, M.D.; Hans Peters, M.D.; and Robert G. Ellison, M.D., Medical College of Georgia, Augusta, Georgia, "Metastatic Carcinoma to the Trachea: Report of a Case of Palliation by Resection and Marlex Graft," J. Thoracic Surg. 49:886-892(May)65.

A case of metastatic carcinoma to the trachea from colon, believed to be a second such case in the world literature, is presented. Palliative resection was performed for obstructive symptoms and the thoracic trachea was reconstructed with heavy Marlex mesh covered with a free autologous pericardial graft. The prosthesis retained integrity in spite of the presence of local *Pseudomonas* infection of the trachea. Although the patient died from other metastases, the prosthesis functioned satisfactorily at least five months.

Vandeput, Jacques J., M.D.; James C. Tanner, Jr., M.D.; and Charles Eberhart, M.D., 490 Peachtree Street, N.E., Atlanta 8, Georgia, "Partial Nephrectomy: Experimental Polar Closure with a Free Peritoneal Graft," J. Urol. 93:364-366(Mar)65.

Partial nephrectomy was done on 30 canine kidneys at which time 10-60% of the kidney was resected by transverse amputation. After controlling all active bleeding with suture ligatures, a graft of peritoneum was applied in lieu of renal capsule to the amputated surface, using fine catgut and interrupted sutures to fix it in place. Uniformly good results were obtained and microscopic study of the graft revealed a minimum of adjacent renal atrophy. The practical application of this experiment is that in cases where the renal capsule is not available, either being destroyed by pathologic process or for some other reason, a suitable substitute is easily available and insures the safety of the procedure.

Dimon, Joseph H. III, M.D.; F. James Funk, Jr., M.D.; and Robert E. Wells, M.D., 1938 Peachtree Road, N.E., Atlanta 9, Georgia, "Congenital Indifference to Pain with Associated Orthopedic Abnormalities," South. M.J. 58:524-529(April)65.

The author discusses two siblings who represent the syndrome of congenital indifference to pain. The orthopedic abnormalities are emphasized. The point of greatest interest in this pain indifference syndrome is that there are no objective findings of malfunction of the nervous system, i.e., the peripheral nerve complex is intact, reflexes are normal, and there is a normal response to changes in temperature, touch, vibration and position sense. The clinical problems range from repeated injuries, including Charcot-like changes in the joints, painless fracture, etc., to "silent fractures" of the lumbar vertebrae with resultant paralysis of the lower extremities. It is thought that the treatment lies primarily in education of the patient and family, hoping to prevent serious problems, but otherwise, dealing with these as they arise.

Guest, James L., Jr., M.D.; David P. Hall, M.D.; and Robert G. Ellison, M.D., Medical College of Georgia, Augusta, Georgia, "Symmetrical Gangrene Following Insertion of a Ball Valve Mitral Prosthesis in a Patient with Giant Left Atrium," J. Thoracic Surg. 49:550-556(April)65.

The Starr-Edwards caged ball prosthesis has proved to be the most successful valve substitute yet produced. Still many potential problems exist with its use. Recently a 43-year-old Negro housewife was evaluated at the Eugene Talmadge Memorial Hospital for progressive exertional dyspnea of six years' duration. Work-up revealed mitral stenosis, mitral insufficiency and tricuspid insufficiency. EKG showed auricular fibrillation and left ventricular hypertrophy. Cardiac x-ray series showed enormous aneurysmal enlargement of the left atrium. The past medical history was remarkable. A Starr-Edwards mitral valve prosthesis was inserted uneventfully. Four days postoperatively incipient gangrene of the legs was noticed, followed shortly by gangrene of all the fingers. Anticoagulants were begun immediately. Ultimately amputation of all fingers and both legs above the knees was necessary. Intermittent jaundice, azotemia, fluctuating delirium and oculomotor disturbances, left pleural effusion, massive G. I. bleeding, Staphylococcal septicemia, uncontrollable cardiac arrhythmias and, terminally, anasarca culminated in the death of the patient five weeks postoperatively. Autopsy showed clot in the left atrium and embolization of practically every organ. Thrombosis in the giant left atrium despite early postoperative anticoagulation was believed to be primarily responsible.



Dixon, Sewell, Jr., M.D.; Sam Hyde III, M.D.; Robert P. Leonard, M.D.; and Robert C. Schlant, M.D., 69 Butler Street, S.E., Atlanta 3, Georgia, "Failure of Glucose-Insulin-Potassium Infusion to Modify the Consequences of Acute Coronary Artery Ligation," *J. Thoracic Surg.* 49:762-766(May)65.

The value of the administration of a "polarizing" solution of potassium-glucose-insulin, recently said to represent a new therapeutic approach in the treatment of cardiovascular disease and to reverse some of the electrocardiographic evidences of myocardial infarction (Sodi-Pallares, et al., *Am. J. Cardiol.* 9:166, 1962), was evaluated by acute ligation of the left anterior descending coronary artery in 13 control dogs and in 16 dogs which were begun on an infusion of this solution at the time of ligation. Electrocardiograms, arterial pressure and stroke output, arterial serum potassium, and coronary sinus serum potassium, pH and CO<sub>2</sub> were obtained at intervals before and following ligation. There was no difference in the incidence of ventricular fibrillation between the control (69.2%) and the treated (68.8%) dogs; further, no significant differences were detected in other variables measured following ligation. However, those dogs in both groups which did develop ventricular fibrillation had a more marked rise in coronary sinus potassium prior to the development of ventricular fibrillation than did the non-fibrillators.

Under the conditions of this study, the infusion of this solution had no protective effect in preventing the development of EKG changes or ventricular fibrillation or in altering the hemodynamic changes following acute coronary artery ligation.

Shippey, Stuart H., Jr., M.D. and James J. Acker, M.D., 69 Butler Street, S.E., Atlanta 3, Georgia, "Segmental Infarction of the Colon Demonstrated by Selective Inferior Mesenteric Angiography," *Am. J. Surg.* 109:671-675(May)65.

Mesenteric vascular occlusion is a long recognized condition, but only recently has it been possible to diagnose and treat these lesions satisfactorily. Most of the cases reported have described acute or chronic occlusions of the superior mesenteric artery. Recent refinements in selective angiography of the mesenteric arterial circulation have provided new knowledge of the normal anatomy and physiology as well as earlier and more accurate diagnosis of pathological changes.

The case of a 67-year-old woman with acute occlusion of a branch of the left colic artery is presented. Collateral circulation prevented complete necrosis of the splenic flexure, but it healed leaving a fibrotic, stenosed segment 18 cm. in length. The diagnosis was suspected on serial barium enemas, and confirmed by selective injection of the inferior mesenteric artery. Surgical resection of the stenosed segment led to complete recovery.

The relationship of this lesion to others in the literature diagnosed as "segmental ulcerative colitis" and "regional enteritis" is discussed. Segmental bowel ischemia is felt to be the etiology in a certain percentage of these cases.

Guest, James L., Jr., M.D.; David P. Hall, M.D.; Thomas J. Yeh, M.D., and Robert G. Ellison, M.D., Medical College of Georgia, Augusta, Georgia, "Late Manifestations of Trauma to the Pericardium," *Surgery, Gynec. and Obst.* 120:787-791(April)65.

Penetrating and non-penetrating thoracic trauma have been recognized with increasing frequency in recent years as significant causes for pericardial disease. Five cases of delayed traumatic pericardial syndromes are reported from the Medical College of Georgia hospitals. The time of onset varied from 18 months to one month following the injury. In two patients a stabwound of the chest was the inciting injury. In three patients automobile accidents with steering wheel injuries to the front of the chest were responsible. Three patients presented with a clinical picture of slowly progressive constrictive pericarditis without apparent relationship to the chest injury. In two patients recurring episodes of pericarditis were disabling. Pericardectomy produced good results in four patients although an associated aortic insufficiency compromised the outcome in one case.

Experimental studies have shown that blood in the pericardial cavity usually is removed very slowly but in individual cases may be quite capricious and unpredictable in its behavior. The factors responsible for this are poorly understood. Although aspiration of acute traumatic hemopericardium produces good results in the majority of patients, pericardectomy may be necessary for symptomatic relief in the occasional patient in whom either constriction occurs or in whom invalidism is created by recurrent pericarditis.

Cibelli, Louis A., M.D., and Edward F. Kerman, M.D., V.A. Regional Office, Atlanta, Georgia, "Will Universal Disability Compensation Decrease Hospital Compensation?" *Dis. Nervous Sys.* 26:111-115(Feb)65.

We have been charged by the Joint Commission on Mental Illness and Health to bring imaginative thinking into the effort directed toward decreasing mental hospital populations and returning a large number of the mentally ill and retarded to the community.

If rejection of the mentally ill is an important consideration in the perpetuation of custodial care in huge, isolated state hospitals, then it follows that means to motivate acceptance of patients by their own families and communities must be found.

The authors believe that they have observed one such motivating force, namely the granting of disability compensation of the mentally ill veteran. Clinical impressions based on long experience in the Veterans Administration lead one to the conclusion that

families of patients, unburdened by the financial aspects of caring for their sick member, and even rewarded by an income to support others who would normally be the veteran's responsibility, are more highly motivated to keep him at home and accept various degrees of deviant behavior which he might exhibit.

A number of specific instances are cited to give credence to the belief that a financially self-sufficient veteran is more highly acceptable in his home than one who is totally dependent on his family.

Skobba, Joseph S., M.D., 490 Peachtree Street N.E., Atlanta, Georgia, "The Private Practitioner and Community Mental Health," *Dis. Nervous Syst.* 26:29-32 (Jan) 65.

Recent emphasis on the development of community mental health facilities has provoked efforts to define the functions of a mental health center and the requirements of a community psychiatrist. It is agreed that the objective is to provide for service which includes a full range of treatment for the patient in or near his home so that there may be continuity of treatment determined by what the patient requires rather than by what is most easily available. It is also pointed out that the psychiatrist must not only be a diagnostician-therapist, but must also be a consultant-teacher as well. The article details the various ways in which a psychiatrist in private practice fulfills the criteria of community psychiatry.

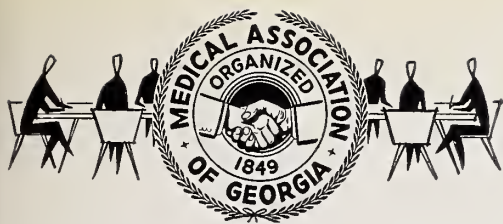
Lewis, John R., Jr., M.D., 478 Peachtree Street N.E., Atlanta 8, Georgia, "The Augmentation Mammoplasty," *Plastic & Recon. Surg.* 35:51-59 (Jan) 65.

The indications for surgical repair of losses or lack of bulk and contour of the breasts are (1) underdevelopment, (2) atrophy, (3) simple ptosis, (4) simple mastectomy, and (5) deficiencies caused by removal of diseased tissues or tumors. The author discusses the repair of these problems and specifically discusses technique utilizing the Silastic Gel Prosthesis which gives a soft, natural feeling breast. He also discusses the reconstruction of the absent nipple and areolar and the reconstruction of the breast, nipple, and areolar following simple mastectomy. Reconstruction of the male breast is also discussed and illustrated.

Harbin, Tom, M.D., Harbin Clinic, Rome, Georgia, "Correction of Spastic Entropion: An Effective Cautery Technique," *Arch. Ophthalmol.* 73:514-515 (April)65.

The author describes a simple office procedure to correct spastic entropion. After procaine infiltration three linear incisions are made in the lower lid using a small National Electric cautery handle with a small platinum wire tip (Storz Instrument Company). Post-operative pain is minimal or absent. Overcorrection has not occurred.





# THE ASSOCIATION

## SOCIETIES

**COBB COUNTY MEDICAL SOCIETY** has recently announced plans to open, in August, an out-patient mental health clinic at the Cobb County Health Center. Providing a drug clinic, emergency treatment and group therapy, the clinic will be supported by the citizens of Cobb County with no assistance from the state or federal governments. The medical staff of the clinic have offered their services free of charge according to W. H. Benson, M.D., a member of the clinic planning committee. Other members of the planning committee include A. I. Miller, M.D.; Martin Gould, M.D.; Ernest Thompson, M.D.; and Siegfried Wurster, M.D.

Max Sadove, M.D., Professor of Surgery and Chairman of the Department of Anesthesiology of the University of Illinois Research and Education Hospital, Chicago, was the special guest speaker at the May meeting of the **GEORGIA MEDICAL SOCIETY**, Savannah. Dr. Sadove, a nationally known authority in the field of intensive care for hospital patients, spoke on "Medical and Surgical Intensive Care."

The latest methods of medical care and emergency treatment of snake bite victims was the topic of the meeting of the **RANDOLPH-STEWART-TERRELL MEDICAL SOCIETY** held in Richland, May 11, 1965. Army Major L. W. Fisher, member of the doctors corps at Martin Army Hospital, Ft. Benning, Georgia, was the guest speaker of the evening. Major Fisher and his assistants are members of the Snake Team for the 11th Air Assault Division, and teach the identification of poisonous snakes, as well as emergency treatment to the troops.

**THOMAS-BROOKS COUNTY MEDICAL SOCIETY** held its quarterly meeting at Archbold Memorial Hospital, Thomasville, June 17, 1965. Featured on the program were Edwin L. Brackney, M.D., Augusta, speaking on "Surgical Treatment of Duodenal Ulcer at Talmadge Memorial Hospital," and Waldo E. Floyd, Jr., M.D., Macon, whose topic concerned, "Reconstruction Procedures and Traumatic Hand Injuries."

## PERSONALS

**EIGHT GEORGIA** physicians have recently been designated as Fellows and Associates of the American College of Physicians. Elected as Fellows were **THOMAS D. JOHNSON**, Albany; **JOHN F. STEGEMAN**, Athens; and **J. NORMAN BERRY**, **JOHN T. GALAMBOS**, and **LOUIS K. LEVY**, all of Atlanta. Elected as Associates were **ROBERT L. RAINEY**, Augusta; **ROBERT M. FINE**, Decatur; and **WILLIAM E. HOLLADAY**, Marietta.

The Georgia Association of Pathologists held its annual meeting on May 11, 1965, in Augusta in conjunction with the annual meeting of the Medical Association of Georgia. The following officers were elected for 1965-66: President, **MENARD IHNEN**, Augusta; President-elect, **ROBERT E. PERRY**, Brunswick; Secretary-Treasurer, **HUGH V. BELL**, Atlanta.

### First District

**IRVING VICTOR**, Savannah, was recently elected President of the Georgia Urological Association and Secretary-Treasurer of the Medical College of Georgia Foundation. He was elected at MAG Annual Sessions conferences in Augusta, May 2-4, 1965.

### Fourth District

**HUBERT FRANKLIN ANTHONY** is leaving his work as Assistant Professor in Radiology at the Medical College of Georgia, Augusta, to become full-time radiologist and Chief of the Department of Radiology of Upson County Hospital, Thomaston.

### Fifth District

**JAMES T. KING**, Atlanta, has recently been elected to membership in the American Laryngological Association. He was also a guest speaker at the Virginia Society of Ophthalmology and Otolaryngology which met at Williamsburg, May 5-8, 1965. His topics were entitled, "Injections Into the Tonsil Fossa to Alleviate Post Tonsillar Pain and Infection, Pro and Con," and "Refractory Serous Otitis Medica."

**BRUCE LOGUE**, Atlanta, was recently visiting professor at the University of Florida, Gainesville, and a guest speaker at the meetings of the Florida Heart Association in Orlando, Florida.

**WARREN J. BROWN**, Atlanta, has recently been certified by the American Board of Plastic Surgery, Inc.

A program on mouth-to-mouth resuscitation and closed chest massage was the educational theme of the Fulton County Association of Medical Assistants' meeting held June 14 at the Academy of Medicine, Atlanta. A color film, "The Pulse of Life," was featured, and demonstrations of resuscitation and massage were given by **LESTER RUMBLE, JR.**, Director of Medical Education at St. Joseph's Hospital, Atlanta.

The Georgia chapter of the American Academy of Pediatrics has received the State Chapter Award for its program of furthering the academy's goals of improved child health.

A plaque and \$2,500, made possible by a pharma-

## THE ASSOCIATION / Continued

ceutical firm, was recently presented to JOSEPH H. PATTERSON, Georgia chapter chairman and chief physician of the Henrietta Eggleston Hospital for Children.

W. W. COPPEDGE, East Point, has been installed as President of the Atlanta Obstetrics and Gynecology Society. He was installed by outgoing President W. H. GRIMES, JR., Atlanta.

### Seventh District

Marietta physician, JONATHAN SWIFT, was recently

honored by Cobb High School athletic coaches for his services in conducting a series of clinics to establish guidelines for a comprehensive safety program in athletics for Cobb County. Dr. Swift was presented an inscribed plaque.

### Tenth District

RICHARD OWINGS of Augusta recently took part in a one-day pediatric surgical symposium in Boston honoring Robert E. Gross, M.D., Professor of Pediatric Surgery at Harvard Medical School. The participating doctors were all former surgical residents trained by Dr. Gross.

\* \* \*

A manufacturer's net profit on the average drug prescription, which costs \$3.35, is only 16 cents.

## AMERICAN FEDERATION FOR CLINICAL RESEARCH ELECTS CALIFORNIAN AS 25TH PRESIDENT

Dr. Richard J. Havel, Associate Professor of Medicine at the University of California School of Medicine, San Francisco, California, became the 25th President of the American Federation for Clinical Research during the course of the Federation's annual national meeting held in Atlantic City, May 2, 1965. The Federation is the nation's largest society of physicians engaged in research and teaching. Some 4,000 members and guests were in attendance at the 1965 meeting.

Dr. Havel succeeded Dr. Morton D. Bogdonoff, Professor of Medicine at Duke University School of Medicine, Durham, North Carolina. Dr. William E. Huckabee, Associate Professor of Medicine at the Boston University School of Medicine in Boston, Massachusetts, was elected President-elect to succeed Dr. Havel in 1966.

## FOUR DOCTORS TO SERVE IN '66 GENERAL ASSEMBLY

Four seats in the House of Representatives at the 1966 session of the Georgia General Assembly will be filled by physicians. This is two less than the record number of six held during the previous term.

These four physician-legislators, all members of the Medical Association of Georgia, are: CHARLES B. WATKINS, Ellijay; A. SID JOHNSON, SR., Elberton; CARL P. SAVAGE, Montezuma; and, FRANK P. HOLDER, JR., Eastman. Dr. Watkins is the lone Republican. The remaining three are Democrats.

These physicians are all veteran legislators, having served previous terms in the House or Senate, and in the case of Dr. Frank Holder, both.

Dr. Grady Coker, Canton, one of the six who served in the House of Representatives last year, retired from active political life and did not offer for re-election. Three other physicians were defeated in their bid for seats in the State House.

The General Assembly will convene its regular 1966 session on January 10th.



**JOURNAL**  
OF THE MEDICAL  
ASSOCIATION

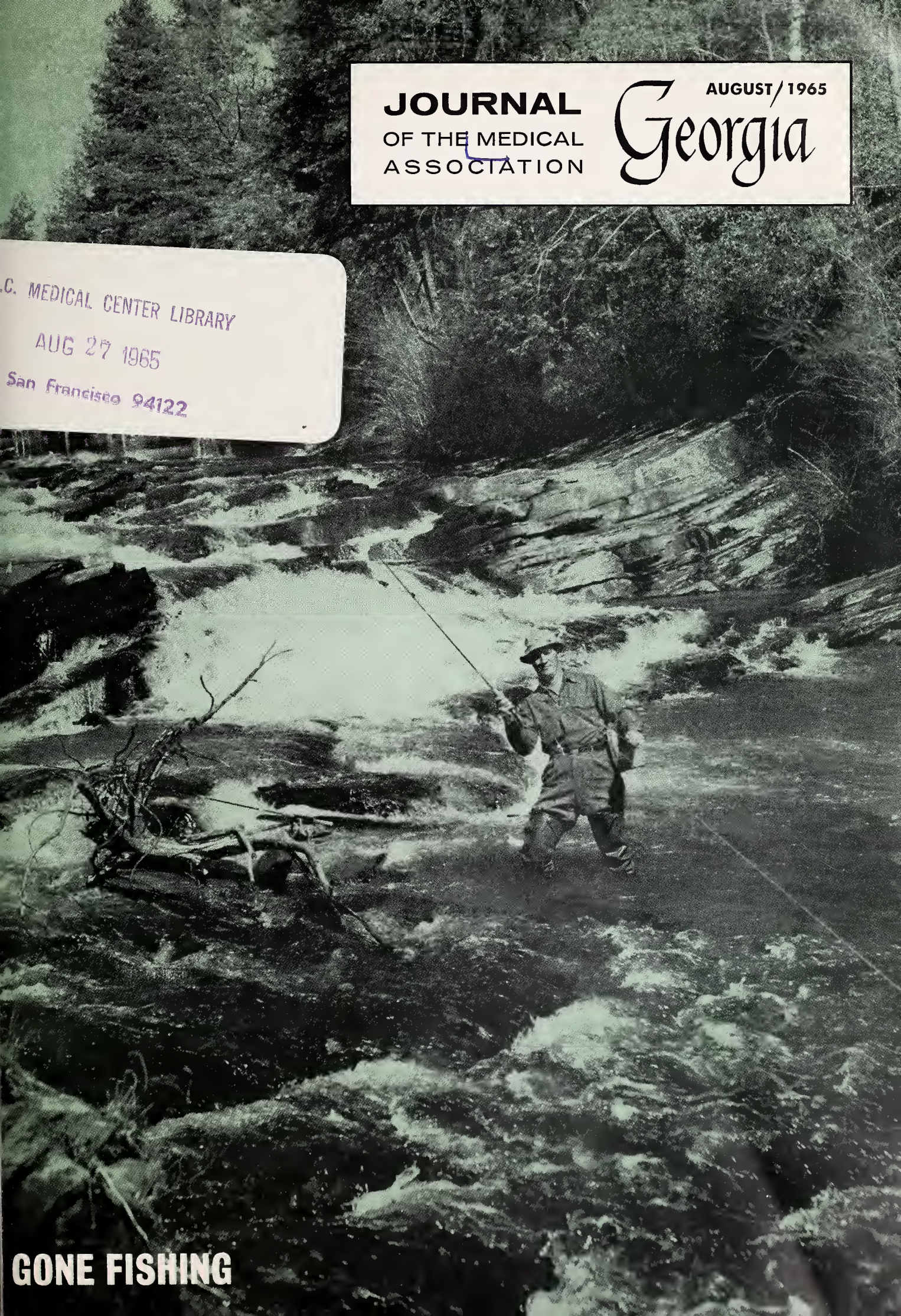
AUGUST/1965

Georgia

U.C. MEDICAL CENTER LIBRARY

AUG 27 1965

San Francisco 94122



**GONE FISHING**





an important contribution to the practice of medicine

# CHLOROMYCETIN<sup>®</sup>

(CHLORAMPHENICOL)

PARKE-DAVIS

PARKE, DAVID & COMPANY, DUBLIN, IRELAND

Complete information for usage available to physicians upon request.

75043



**JOURNAL**  
OF THE MEDICAL  
ASSOCIATION

*Georgia*

**EDITOR**  
Edgar Woody, Jr., M.D.

**MANAGING EDITOR**  
Miss Merrilie M. Davis

**STAFF**  
Thelma V. Franklin, *Business*

**CONTRIBUTING EDITORS**  
Herbert S. Alden, M.D.; Preston D. Ellington, M.D.; Thomas Findley, M.D.; J. Willis Hurst, M.D.; Charles S. Jones, M.D.; Arthur M. Knight, Jr., M.D.; Arthur J. Merrill, M.D.; Lester Rumble, Jr., M.D.; Peter L. Scardino, M.D.; Patrick C. Shea, Jr., M.D.; Robert H. Vaughan, M.D.

**PUBLICATIONS COMMITTEE**  
J. G. McDaniel, M.D.; George H. Alexander, M.D.; George R. Dillinger, M.D.; John Kirk Train, M.D.; A. W. Simpson, M.D.; John T. Mauldin, M.D.; John S. Atwater, M.D.; C. R. Andrews, M.D.

**THE ASSOCIATION**  
J. G. McDaniel, M.D., *Pres.*; George H. Alexander, M.D., *Pres.-Elect.*; George R. Dillinger, M.D., *Past Pres.*; A. W. Simpson, M.D., *Chm. of Council*; John T. Mauldin, M.D., *Sec.*; John S. Atwater, M.D., *Treas.*; J. Frank Walker, M.D., *Speaker*; Mr. Milton D. Krueger, *Exec. Sec.*; Mr. James M. Moffet, *Asst. Exec. Sec.*; Mrs. Catherine Wooten, *Asst. Exec. Sec.*

THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and copyrighted, 1965, by the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309. Published monthly under the direction of the Council of the Association. Subscription rate: \$7 per year; \$1 per single copy. Application to mail at second-class postage rates is pending at Fulton, Missouri.

**Contents**

**Scientific Articles**

THE ROLE OF STARVATION AND HYPOCALORIC DIETS IN THE MANAGEMENT OF OBESITY Ruben A. Puebla, M.D. and Robert B. Greenblatt, M.D.	267
--	-----

EXPERIENCE IN MANAGEMENT OF ARTERIOSCLEROTIC ANEURYSMS Garland D. Perdue, Jr., M.D.	271
---	-----

AN EXPLANATION OF PLACENTAL MARGINAL INFARCT RINGS Richard Torpin, M.D.	274
---	-----

PSEUDOMONAS TOXEMIA OF BURNS, ITS ORIGIN, SIGNIFICANCE AND CONTROL H. Harlan Stone, M.D.	277
--	-----

SMOKING HABITS AND HEALTH IN GEORGIA AND OTHER SOUTHERN STATES E. Cuyler Hammond, Sc.D. and A. H. Letton, M.D.	278
--	-----

**Editorials**

RICHARD TORPIN AND PLACENTATION	282
AMA ANNUAL MEETING HIGHLIGHTS	282

Features		The Association	
President's Letter	284	Deaths	288
		Societies	288
Heart Page	285	Personals	288
		Advertising Index	46A
Legal Page	287	Calendar	289

**Cover**

Photo courtesy of Mr. Kenneth Rogers, *Atlanta Journal-Constitution Sunday Magazine*.





4:02 am



4:08 am



4:17 am

The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say

things go  
better  
with  
**Coke**  
TRADE-MARK ®



# THE ROLE OF STARVATION AND HYPOCALORIC DIETS IN THE MANAGEMENT OF OBESITY

Ruben A. Puebla, M.D.

Robert B. Greenblatt, M.D., *Augusta*

■ A careful clinical documentation of a well-established procedure is presented.

GENETIC, ENVIRONMENTAL, metabolic and endocrine factors, in general, have been overlooked in the management of obesity because it has become a habit of thought to consider all obesity as exogenous in origin. In recent years, short or prolonged starvation periods have been advocated before initiating a treatment regimen of reduced caloric intake.<sup>1-5</sup> The weight changes, however, during periods of starvation or severe hypocaloric diets seemed to violate the laws of thermodynamics. Some patients have lost as much as ten pounds during the first day of starvation; others have gained on diets of 500 calories, especially when such a diet followed a period of starvation. The purpose of this paper is to present our experience with 50 obese females treated by starvation and various hypocaloric diets, and to compare our findings with those previously reported in the literature.

## Material and Methods

All patients were more than 20% overweight according to "height-weight" tables<sup>6</sup> and were hospitalized for the entire period of observation. The age range varied from 13 to 44; the average, 26.8 years. The sequence of starvation and hypocaloric intake and the length of such periods were variable.

CONTENT OF HYPOCALORIC DIETS  
(Gms./day)

Diet	CHO	Prot.	Fat	Na	K
250 calories	11.1	25.0	10.3	1.3	1.3
500 calories	30.5	38.5	25.0	1.3	1.4
1000 calories	121.0	61.0	30.0	1.3	2.3

Non-nutritious fluids such as black coffee, tea and water were allowed ad libitum during fasting periods. The amount of carbohydrates, proteins, fats, sodium and potassium in each of the hypocaloric diets em-

TABLE I  
AVERAGE WEIGHT LOSS WITH VARIOUS DIETS  
AND/OR MEDICAMENTS

No. of Patients*	Diet	Medication**	Duration No. Days	Average Duration No. Days	Total Wt. Loss in Lbs.	Average Daily Wt. Loss in Lbs.
55	Starvation	None	302	5.5	552.8	1.83
6	Starvation	Diuretic	34	5.7	52.2	1.54
1	Starvation	Thyroid	2	2.0	1.8	.88
2	Starvation	Diuretic & Thyroid	15	7.5	8.0	.53
33	250 Calories	None	170	5.2	155.3	.91
33	250 Calories	Diuretic	163	4.9	137.0	.84
1	250 Calories	Thyroid	5	5.0	2.0	.40
7	250 Calories	Diuretic & Thyroid	51	7.3	32.5	.64
10	500 Calories	None	32	3.2	2.8	.09
8	500 Calories	Diuretic	32	4.0	21.5	.67
1	500 Calories	Diuretic & Thyroid	2	2.0	1.3	.63
18	1000 Calories	None	39	2.2	29.8	.76
4	1000 Calories	Diuretic	9	2.5	3.0	.33
6	Regular or Normal	None	15	2.5	9.5	.63

\* Some of the patients received the same diet twice.

\*\* Hydrochlorothiazide and potassium chloride 50-75 mg. daily or Spironolactone and hydrochlorothiazide 200-300 mg. daily and Cytomel 25-75 µg. daily.

TABLE II  
AVERAGE WEIGHT LOSS AS RELATED TO THE  
INITIAL DIETARY REGIMEN

No. of Patients	Diet	Medication	Duration No. Days	Average Days Per Patient	Total Wt. Loss in Lbs.	Average Daily Wt. Loss in Lbs.
15	Starvation	None	87	5.8	148.2	1.7
2	Starvation	Diuretic*	16	8.0	35.3	2.2
15	250 Calories	None	79	5.6	98.0	1.2
5	500 Calories	None	15	3.0	17.0	1.1
10	1000 Calories	None	25	2.5	30.5	1.3
6	Normal	None	15	2.5	9.5	0.63

\* Hydrochlorothiazide and potassium chloride 50-75 mg. daily.

TABLE III  
AVERAGE WEIGHT LOSS IN PATIENTS ON STARVATION  
DIET FOLLOWED BY 250 CALORIE DIET

Patient	Starvation Diet				250 Calorie Diet			
	Days	Wt. Loss	Wt. Gain	Average Daily Wt. Loss in Lbs.	Days	Wt. Loss	Wt. Gain	Average Daily Wt. Loss or Gain Lbs.
M.G. ....	11	5.75	—	.5	4	—	2.5	+ .63
S.J. ....	4	14.0	—	3.5	10	3.5	—	.35
F.L. ....	11	15.0	—	1.4	5	2.5	—	.50
R.I. ....	3	5.0	—	1.7	3	5.0	—	1.70
B.B. ....	2	7.75	—	3.9	2	—	.3	+ .13
TOTAL ....	31	47.5	—	1.5	24	11.0	2.8	0.35

TABLE IV  
AVERAGE WEIGHT LOSS IN PATIENTS ON 250 CALORIE  
DIET FOLLOWED BY STARVATION DIET

Patient	250 Calorie Diet				Starvation Diet			
	Days	Wt. Loss	Wt. Gain	Average Daily Wt. Loss in Lbs.	Days	Wt. Loss	Wt. Gain	Average Daily Wt. Loss in Lbs.
G.C. ....	7	8	—	1.1	3	3.5	—	1.2
M.W. ....	6	13	—	2.2	6	6.0	—	1.0
D.E. ....	6	15	—	2.5	5	8.0	—	1.6
D.H. ....	5	6	—	1.2	5	5.8	—	1.2
P.V. ....	6	8	—	1.3	3	3.0	—	1.0
TOTAL ....	30	50	—	1.7	22	26.3	—	1.2

ployed is shown in Chart 1. The dietary sodium content was constant (1.3 gm/day) but the content of other elements varied with the caloric intake. Fasting blood sugar, plasma CO<sub>2</sub>, sodium and potassium in plasma and urine determined on the Auto-Analyzer (Technicon), as well as urinary 17-ketosteroids<sup>7</sup> and 17-ketogenic steroids,<sup>8</sup> were carried out in most patients before and after each dietary regimen. Urine acetone was tested daily in all and serum acetone<sup>9</sup> was determined every other day in five patients. Daily 24-hour urine collections for sodium and potassium determinations were obtained in four patients during their entire hospitalization. Observations were made on the relationship between weight, ketone body formation, fluid and electrolyte changes.

Interpretation of Results

Table I shows the average weight loss on each regimen. At first glance there does not appear to be any correlation between weight loss and the various regimens attempted—for example, the mean daily weight loss with starvation and diuretic and/or thyroid was less than with starvation alone, and the average daily weight lost on a normal diet was greater than with a 1,000 calorie diet and diuretic. These contradictions are understandable if one realizes that the metabolic readjustment is frequently abnormal in the obese patient during starvation and hypocaloric diets.<sup>10-17</sup> Moreover, the marked variations occurred because of the order in which the diets were given. This factor became obvious when the average weight loss in relation to the initial dietary regimen was studied (Table II). Weight loss was greater with starvation and a diuretic than on starvation alone, and surprisingly, weight loss was less with 250 and 500 calories than with a 1,000 calorie diet because of the decided antidiuretic and antinaturetic effect of severe calorie restriction.<sup>3, 11</sup> The weight loss during starvation was five times greater than during the 250 calorie period which immediately followed (Table III). The minor loss of weight (0.35 pounds daily) which occurred while on the 250 calorie diet following starvation may be explained by the “sodium conserving effect” of carbohydrates after fasting. This phenomenon is unaffected by exogenous proteins, fat or sodium chloride.<sup>15, 18, 19</sup> On the other hand, it is important to point out, when a dietary period of 250 calories preceded the period of starvation, the weight loss during starvation was less by 0.5 pounds per day than on the restricted diet (Table IV). This contradictory finding may be explained by the abnormal diuresis which takes place in the obese in the recumbent position; the position most often adopted by patients during the first few days of hospitalization.<sup>3</sup>



A daily evaluation of the disturbances in water and electrolyte balance was obtained in four patients during normal diet, starvation and 250 calorie diet with and without diuretics. The relationship between body weight, urine volume, urinary sodium and potassium excretion is shown in Figure 1. A progressive decrease in naturesis (from 103 to 20 meq daily) as well as a constant high potassium excretion was noted during fasting periods. A direct relation between naturesis and weight loss was apparent during the period of starvation. However, during the period of 250 calorie intake which followed the period of starvation, the sodium and potassium excretion remained low and gain in weight was noted. When 25 mg. of spironolactone and 25 mg. of hydrochlorothiazide (Aldactazide A\*) were added to this diet, a marked increase in sodium excretion was noted which paralleled the decrease in body weight. Caloric restriction, it appears, induced a marked antidiurectic and antinaturetic effect. Furthermore, the sodium conserving influence of carbohydrates following fasting could be blocked by the combination of hydrochlorothiazide\*\* and spironolactone. This effect, however, was not ob-

\* Supplied by G. D. Searle and Company, Chicago, Illinois.  
\*\* Supplied by Ciba Pharmaceutical Company, Summit, New Jersey.

RELATION OF BODY WEIGHT AND URINARY ELECTROLYTES DURING VARIOUS DIETARY REGIMENS.

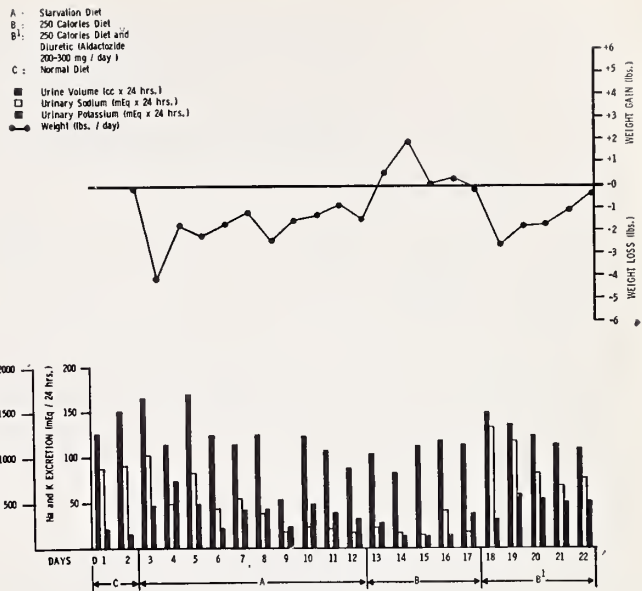


FIGURE 1

Changes in body weight, urine volume, urinary sodium and potassium excretion levels during various dietary regimens (results are expressed as an average of 4 patients similarly treated). Note apparent relationship between sodium excretion and loss in body weight during starvation. The patients gained weight on a 250 calorie diet despite low sodium excretion, but further weight loss was induced with a diuretic.

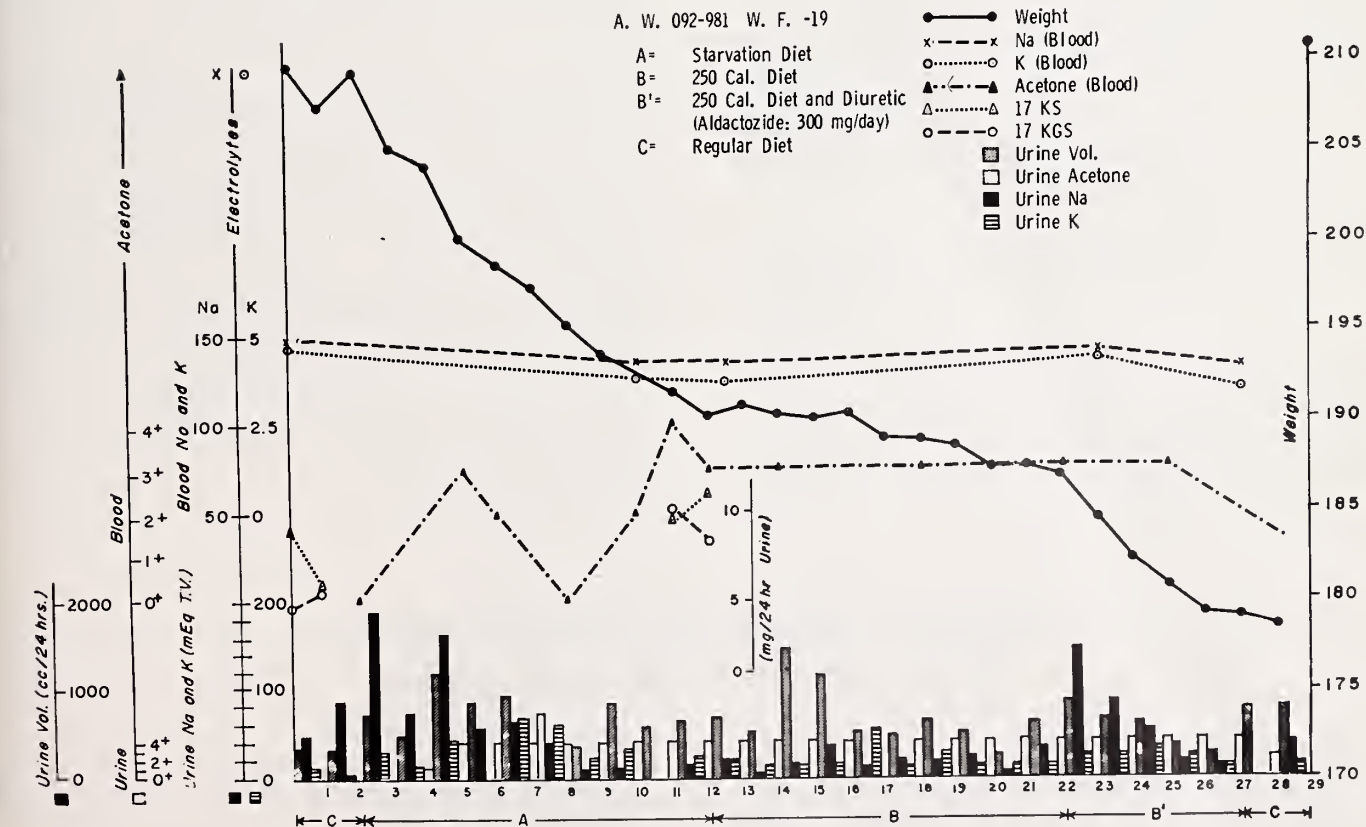


FIGURE 2

Serum and urinary sodium, potassium and acetone levels and urinary 17-ketosteroid and ketogenic steroid values in an obese patient under various dietary regimens. Note only minor changes in serum electrolytes in contrast to marked changes in urinary electrolytes.

tained when only an antialdosterone agent was employed.<sup>20</sup>

In our studies, the onset of paradoxical anorexia, reported during fasting by Bloom<sup>1</sup> and by Duncan<sup>2</sup> paralleled the development and degree of ketonemia. No significant changes in serum levels of Na, K, CO<sub>2</sub>, pH of blood, glycemia, urinary 17-ketosteroids and 17-ketogenic steroids were noted during starvation and/or different dietetic periods (Figure 2). The response to the various schemes was also influenced by the duration of the obesity. The response to treatment was greater in patients in whom the obesity was relatively recent and poor in those in the so-called "static phase."<sup>11</sup>

### Conclusions

Our results are in agreement with other investigators concerning the effectiveness of starvation and severe hypocaloric diets in the treatment of obesity. Because of abnormal adjustment mechanisms in the obese to water and electrolyte metabolism, the sequence of starvation and hypocaloric diets may produce contradictory results. In our series we found that: a) most of the weight lost during first fasting period was mainly due to loss of water and electrolytes; b) a tendency to rapid restoration of water loss and electrolytes occurred immediately following the fasting period on the ingestion of food; c) the comparable weight loss in patients on severe hypocaloric diets was less because of the antinatriuretic and antidiuretic effects of such diets; d) administration of a mixture of hydrochlorothiazide and aldosterone blocking agents prevented the rapid tendency to weight gain after fasting periods.

Because of the poor weight loss so often obtained on severely restricted diets, it is our belief that better results are obtained by a diet of moderate caloric intake (1,000-1,200 calories daily): low in carbohydrates, high in proteins, normal in fat and low in sodium as proposed recently by Gordon et al. To initiate a dietary regimen for weight loss in the man-

agement of the obese patient, a preliminary starvation period is advisable in order to interfere with the adaptive mechanisms of increased lipogenesis present in the obese.

### REFERENCES

1. Bloom, W. L.: Fasting as an Introduction to the Treatment of Obesity, *Metabolism*, 8:214, 1959.
2. Duncan, G. G., et al.: Correction and Control of Intractable Obesity, *J.A.M.A.*, 181:309, 1962.
3. Gordon, E. S.; Goldberg, M., and Chosy, G. J.: A New Concept in the Treatment of Obesity, *J.A.M.A.*, 186:50, 1963.
4. Duncan, G. G.; Jensen, W. K.; Cristofori, F. C., and Schless, G. L.: Intermittent Fasts in the Correction and Control of Intractable Obesity, *Amer. J. Med. Sc.*, 245:515, 1963.
5. Drenick, E. J.; Swendseid, M. E.; Blohd, W. H., and Tuttle, S. G.: Prolonged Starvation as Treatment of Severe Obesity, *J.A.M.A.*, 187:100, 1964.
6. Metropolitan Life Insurance Company, Statistical Bureau, 1943.
7. Drekter, I. J.; Heister, A.; Scism, G. R.; Stern, S.; Pearson, S., and McGavack, T. H.: The Determination of Urinary Steroids. I. The Preparation of Pigment-free Extracts and a Simplified Procedure for the Estimation of Total 17-Ketosteroids, *J. Clin. Endocrinol. & Metab.*, 12:55, 1952.
8. Norymberski, J. K.; Stubbs, R. D., and West, H. F.: Assessment of Adrenocortical Activity by Assay of 17-Ketogenic Steroids in Urine, *Lancet*, 264:1276, 1953.
9. Lyon, J. and Bloom, W. L.: The Use of Furfural for the Determination of Acetone Bodies in Biological Fluids, *Canad. J. Biochem.*, 36:1047, 1958.
10. Newburgh, L. H.: Obesity, *Arch. Int. Med.*, 70:1033, 1942.
11. Gordon, E. S.: New Concepts of the Biochemistry and Physiology of Obesity, *Med. Clin. North Amer.*, 48:1285, 1964.
12. Bloom, W. L.: Electrolyte Metabolism in Obesity and During Fasting, *Med. Clin. North Amer.*, 48:1399, 1964.
13. Bansi, H. W. and Olsen, J. M.: Water Retention in Obesity, *Acta Endocrinol.*, 32:113, 1959.
14. Berkowitz, D.: Metabolic Changes Associated with Obesity and After Weight Reduction, *J.A.M.A.*, 187:399, 1964.
15. Bloom, W. L. and Azar, G. J.: Similarities of Carbohydrate Deficiency and Fasting. I. Weight Loss, Electrolyte Excretion and Fatigue, *Arch. Int. Med.*, 112:333, 1963.
16. Duncan, G. G.; Cristofori, F. C.; Yue, J. K., and Murthy, M. S. J.: The Control of Obesity by Intermittent Fasts, *Med. Clin. North Amer.*, 48:1359, 1964.
17. Elsbach, P. and Schwartz, I. L.: Salt and Water Metabolism During Weight Reduction, *Metabolism*, 10:595, 1961.
18. Wright, H. K.; Gann, D. S., and Albertsen, H.: Effect of Glucose on Sodium Excretion and Renal Concentrating Ability After Starvation in Man, *Metabolism*, 12:804, 1963.
19. Bloom, W. L.: Inhibition of Salt Excretion by Carbohydrates, *Arch. Int. Med.*, 109:26, 1962.
20. Gersing, A. and Bloom, W. L.: Glucose Stimulation of Salt Retention in Patients with Aldosterone Inhibition, *Metabolism*, 11:329, 1962.

## PHARMACY IMPRINTED PRESCRIPTION BLANKS DEEMED UNETHICAL FOR PHYSICIAN USE

BE IT RESOLVED, that the Georgia Pharmaceutical Association endorse the American Medical Association's opinion "It is unethical for physicians to use prescription blanks with the name of a pharmacy printed thereon," and

BE IT FURTHER RESOLVED, that the Georgia Pharmaceutical Association hereby declares it un-

ethical for a pharmacist to supply to the physician prescription blanks imprinted with the pharmacy name or similar advertising.

ADOPTED April 14, 1965

90th Annual Convention, Georgia Pharmaceutical Association



# EXPERIENCE IN MANAGEMENT OF ARTERIOSCLEROTIC ANEURYSMS

Garland D. Perdue, Jr., M.D., *Atlanta*

- The presence of other manifestations of arteriosclerosis frequently complicates the management of these lesions.

**T**HE MULTIPLE HAZARDS OF arteriosclerotic aneurysms often are not fully appreciated because of the innocuous appearance of the asymptomatic lesion. Experience with management of more than one hundred of these lesions does indicate that complications are frequent, and that these are of a catastrophic nature.

## Pathology

Localized dilatation of a blood vessel results in local turbulence of blood flow, with increased lateral pressure. This results in continuing lateral expansion of the dilatation, and pre-disposes to thrombosis within the lumen of the aneurysm. Complications may arise from both of these phenomena. Disastrous effects from pressure on adjacent structures are comparatively rare, and complications arise primarily as the result of continuing expansion with ultimate rupture and hemorrhage, or from the propagation or dislodgement of the mural thrombus within the aneurysm. The location of the aneurysm may be of deciding importance in determining the natural evolution of the lesion.

## Aneurysms in the Extremities

Aneurysms in the extremities are limited in their lateral expansion by the tightness and strength of surrounding fascial and muscular structures. Rupture and hemorrhage is a more uncommon complication than when the lesion is located in a blood vessel within a body cavity. The most common of the complications of aneurysms of the extremities are the direct result of the intra-luminal thrombus which is almost invariably present. Continuing propagation of this thrombus may ultimately result in significant limitation of blood flow through the aneurysm with secondary ischemia of the distal part. Approximate-

ly three-fourths of the patients in our series have sought medical attention, not because of the aneurysm itself, but because of ischemic symptoms secondary to its presence. As a matter of fact, acute thrombosis of such a lesion has been the most common presenting complaint. When this occurs, the symptoms naturally are those of total ischemia of the distal part, and early revascularization is required for salvage of the extremity.

Embolization is a second common complication of the intra-luminal clot. Dislodgement of fragments of the thrombus may result in more distal occlusion of the vessel with resultant ischemia. In many instances, these emboli are quite small, and even microscopic in size, so that the vessels occluded are frequently the size of digital arteries, and the tissue necrosis may be confined to digits. Several examples of femoral and popliteal emboli from more proximal aneurysms have been seen, however, illustrating the variable size of the clot fragments which may be dislodged.

Thus, the complications of aneurysms in the femoral and popliteal region have most commonly been those which are secondary to the intra-luminal thrombus. The presenting symptoms of ischemia combined with the physical finding of an aneurysmal dilatation of the blood vessel suggests the true origin, and the proper line of correction. Experience with asymptomatic lesions which have remained untreated indicates that the acute ischemia problem tends to arise without prior warning. Restorative vascular surgery with excision of the aneurysm is indicated after diagnosis of such a lesion, when the operative risk is reasonable. Acute total ischemia with major vessel involvement requires revascularization for limb salvage.

The characteristics of aneurysms in the body cavities lead to a different set of problems. In the

From the Joseph B. Whitehead Department of Surgery, Emory University School of Medicine, Atlanta, Georgia. Aided by USPHS Grant No. CD-00036-03.

body cavities, the lateral expansion of the aneurysm is not limited by strong fascial or muscular tissues as it is in the extremities, and aneurysms of clinical importance tend to show progressive expansion. In aneurysms of the terminal aorta, which is the most common location, it is rarely possible to be assured that a lesion is present unless its size is greater than some 4 to 5 cms. in diameter. Thus, an aneurysm which is diagnosed by clinical examination would almost certainly have a diameter of 4 to 5 cms. or greater. It has been well shown, in numerous studies, that aneurysms of this size do progressively expand. When aneurysms are greater than 7 cms. in diameter, the usual cause of death is rupture of the lesion, and this will tend to occur in the majority of instances within the first one to two years after diagnosis of the lesion, if it is left untreated. Survival statistics reported by Estes,<sup>3</sup> Wright,<sup>6</sup> Crane<sup>1</sup> and others would indicate an over-all, five-year life expectancy of somewhere between 10% and 20% in patients with untreated aneurysms. This contrasts with an over-all life expectancy of approximately 85% in the general population of comparable age groups. Experience in our series confirms that reported elsewhere, and aneurysms which have been left untreated for observation have, as a general rule, required surgical intervention because of progressive expansion or other symptoms which demand immediate treatment.

### Mural Thrombus a Problem

In this series, the mural thrombus in the aneurysm located in the body cavities has also been a problem. Complete thrombosis has been observed in several instances of small aneurysms of the aorta,<sup>4</sup> but much more commonly, the aneurysm has been a source of peripheral embolization. This has been seen in approximately 10% of our series. It has been such a frequent occurrence that, in several instances which appeared to show characteristics of arterial emboli without an obvious source, we have looked for, and found, small aneurysms of the abdominal aorta which were otherwise unsuspected.

The lethal nature of aneurysms thus seems well established. The difficulty in decision for operation in individual cases occurs because the aneurysm is rarely an isolated lesion. Since it is one of the manifestations of arteriosclerosis, it is the usual experience to find one or more other manifestations of arteriosclerosis located in other vital areas of the body. For example, there is historical, physical or electrocardiographic evidence of arteriosclerotic heart disease in approximately 90% of this series. Hypertension of significant degree is present in over half.

Arteriosclerotic stenosis or occlusion of distal vessels and of carotid vessels frequently co-exist. In addition, the patients often have other manifestations of degenerative disease, and the existence of chronic pulmonary emphysema and chronic tracheobronchitis has been a frequent coincidence in this group.

The mortality risk for operative intervention is definitely greater than would be expected in a similar group of patients without such co-existing diseases. In the performance of the operation, it has been found desirable to pay especial attention to prompt blood volume replacement on a volume for volume basis and to use whatever aids are required to maintain the systemic blood pressure at the preoperative level throughout the course of operation. The most common operative and postoperative complication, and the most common cause of death in our series, has been the occurrence of myocardial infarction. Close cooperation between the surgeon and the cardiologist is required for salvage of a large percentage of these patients.

A complication which was formerly noted with considerable frequency was the occurrence of post-operative oliguria and transient elevation of the blood urea nitrogen. In two instances, death of a patient occurred because of acute tubular necrosis. More recently, careful attention has been paid to pre-operative hydration of the patient, and to use of an osmotic diuretic during the course of the operation to maintain an adequate level of renal blood flow during the time the aorta is cross-clamped. In this way, the incidence of these phenomena has been minimized, and no patient has been lost from acute tubular necrosis who has been treated with this approach.

With increasing experience, certain technical aids have been found to be of considerable help in minimizing sudden acute blood loss and compromise of distal circulation following operation. We attempt to obtain proximal and distal control of the blood vessel with minimal manipulation of the aneurysm in order to prevent dislodgement of intra-mural thrombus. When the vessel is clamped, Heparin is given in an adequate dose to prevent intravascular coagulation. Restoration of vascular continuity, in most instances, requires use of a plastic prosthesis. Increasing attention to insuring good run-off by appropriate end-arterectomy or arterial grafting has resulted in lessening of the incidence of thrombosis in the prosthesis after operation. Since most aneurysms are densely adherent to adjacent veins, the most likely source for acute sudden blood loss is inadvertent entry into the vein. It has become an increasingly routine practice for us to leave the attached wall of the aneurysm in situ when it is densely adherent to the adjacent vein.



A complication which occurred early in our series was the development of ischemic necrosis of the left colon.<sup>5</sup> This occurs primarily because of co-existing occlusive disease in the collateral vessels which supply the recto-sigmoid colon after sacrifice of the inferior mesenteric artery. We have paid particular attention to maintaining adequate flow through these collateral vessels with preservation of at least one and preferably both internal iliac branches with a normal lumen. There has been no further instance of this complication since this practice was instituted. In the last 26 elective operations for aneurysms of the abdominal aorta, no deaths have occurred. In spite of the frequent co-existence of other diseases, we have come to expect that the aneurysm can be successfully managed by careful surgical technique, and attention to the details outlined above. Acute expansion or rupture of aneurysms requiring emergency surgery results in a far less favorable salvage rate. The occurrence of prolonged pain, and in many instances shock, prior to operation and the necessity for doing emergency operation under less than ideal circumstances results in an increasing incidence of all types of postoperative complications, as well as the direct loss from uncontrolled hemorrhage which inevitably occurs when the aneurysm has ruptured.

We have felt fortunate to be able to obtain a salvage rate of approximately 50% of patients in this category.

In summary, aneurysms in body cavities are a lethal lesion which tend to progress fairly rapidly to a fatal complication unless treated. In spite of the co-existence of numerous diseases and other manifestations of arteriosclerosis, it is possible to perform aneurysmectomy with an acceptable mortality risk. It is our belief that even the asymptomatic aneurysm should be operated upon when there is no immediate limitation to the patient's life expectancy.

BIBLIOGRAPHY

1. Crane, Chilton: Arteriosclerotic Aneurysms of the Abdominal Aorta: Some Pathological and Clinical Correlations. *New England J. Med.* 253:954-958, 1955.
2. DeBakey, M. E.; Crawford, E. S.; Cooley, D. A.; Morris, G. C., Jr.; Royster, T. S., and Abbott, W. P.: Aneurysm of Abdominal Aorta: Analysis of Results of Graft Replacement Therapy One to Eleven Years After Operation. *Ann. Surg.* 160:622-639, 1964.
3. Estes, J. E., Jr.: Abdominal Aortic Aneurysm: A Study of One Hundred and Two Cases. *Circulation* 2:258-264, 1950.
4. Perdue, G. D., Jr.: Thrombosis of Aneurysms of the Abdominal Aorta. *J. Med. Assoc. Ga.* 52:201-202, 1963.
5. Perdue, G. D., Jr. and Lowry, K.: Arterial Insufficiency to the Colon Following Resection of Abdominal Aortic Aneurysms. *Surg., Gyn., and Obst.* 115:39-44, 1962.
6. Wright, I. S.; Urdantea, Enrique, and Wright, Barbara: Re-Opening the Case of the Abdominal Aortic Aneurysm. *Circulation* 13:754-768, 1956.

GEORGIA HEART ASSOCIATION  
WILL HOLD ANNUAL MEETING  
AT ATLANTA IN SEPTEMBER

The Seventeenth Annual Scientific Sessions of the Georgia Heart Association will be held Monday and Tuesday, September 20 and 21, at the Atlanta Biltmore Hotel.

Eminent speakers in the cardiovascular field and the subjects of their papers include:

- |  |   |
|--|---|
| <i>Denton A. Cooley, M.D.</i><br><i>Houston, Texas</i>   | 1. "Cardiac Surgery During the First Year of Life"                    |
|  | 2. "Surgical Treatment of Left Ventricular Outflow Tract Obstruction" |
| <i>Mason Sones, M.D.</i><br><i>Cleveland Clinic</i><br><i>Cleveland, Ohio</i>                                  | 1. "Coronary Arteriography —Methodology"                              |
|  | 2. "Acquired Valvular Disease"  |
| <i>William L. Proudfit, M.D.</i><br><i>Cleveland Clinic</i><br><i>Cleveland, Ohio</i>                          | 1. "Coronary Arteriography —Clinical Correlation"                     |
|  | 2. "The Distribution of Arterial Lesions in Coronary Disease"         |
| <i>Hughes Day, M.D.</i><br><i>Dept. of Cardiology</i><br><i>Bethany Hospital</i><br><i>Kansas City, Kansas</i> | 1. "The Value of Intensive Care Units"                                |
|  | 2. "Recorded Arrhythmias in Acute Coronary Patient"                   |

- |   |   |
|---|---|
| <i>Eugene Klatte, M.D.</i><br><i>Dept. of Radiology</i><br><i>Vanderbilt Univ. Hosp.</i><br><i>Nashville, Tenn.</i> | 1. "Practical Consideration in the Plain Film Diagnosis of Heart Disease" |
|   | 2. "The Place of Extra-cardiac Angiography in Modern Medical Practice"    |
| <i>Paul Zoll, M.D.</i><br><i>Beth Israel Hosp.</i><br><i>Boston, Mass.</i>  | 1. "Results and Complications of Conversion of Arrhythmias"               |
|   | 2. "Treatment of A-V Block"   |

The meeting is approved for eight post-graduate hours by the American Academy of General Practice, according to Dr. Louis L. Battey, Georgia Heart Association President.

"Members of the Georgia Heart Association are eligible to attend at no charge. Registration Fee for non-members is \$5.00. Registration Fees are waived for interns, residents, fourth-year students, and doctors on temporary duty in the Armed Services," Dr. Battey said.

Advance registration forms are available through the Georgia Heart Association, 58 Baltimore Place, N.W., Atlanta, Georgia 30308, Telephone 523-7262.

# AN EXPLANATION OF PLACENTAL MARGINAL INFARCT RINGS

Richard Torpin, M.D., *Augusta*

- A significant summary of a life-long evaluation of a concept of placental formation.

**O**BSTETRICS is one branch of medicine that has not, as yet, approached the stature of a science. It is composed of a large group of more or less unrelated facts, a hodgepodge of disconnected items for students to learn about but not to be able to correlate. For instance, 10% of all human pregnancies abort, but no one, in more than 150 years of study, can point out the exact reason in the majority of instances. Why do some abortions become missed abortions, blood moles, Breus subchorial hematoma moles or, very rarely, extramembranous pregnancies, with the fetus continuing alive in the partially naked uterine cavity and subject to various pressure lesions? What is the relation of premature separation of the placenta to spontaneous abortion? Why does the placenta of spontaneous abortions usually cover more of the relative area of the fetal sac than the placenta does at term? There are five or six distinct individual varieties of the human placenta. What is the relationship one to another? No doubt there is some simple bond among these conditions which, if known, would make them much more interesting, not to mention the possible benefits to the afflicted patients.

## Difficult to Visualize

One may find it quite difficult to visualize accurately the pregnant uterus with its fetus and placenta. This is especially so in regard to the placenta, since in one's medical years very little was ever presented as to how and where the placenta lies in regard to the uterine wall. Only in placenta previa was this ever stressed. Most people think in terms of three

dimensions, but in the consideration of the pregnant uterus one must think in terms of an added dimension—that of time, since the relationships, in many cases, constantly change. Probably the easiest is in regard to the perfectly normal placenta which usually occupies approximately one fourth of the uterine cavity and is limited to one anterior or posterior wall. In this case the placenta, at all times in pregnancy, occupies the same relative area of the fetal sac so that fetus, placenta, and uterus all enlarge in unison and there is no tension on the edge of the placenta. It is much more difficult to visualize the situation in which the early placenta occupies more than one fourth of the available area at that time. The placenta in this circumstance might continue to enlarge, occupying the same relative area, in succeeding months, but then it would appear at term in the shape of a mixing bowl, and this apparently does not occur. All discoid placentas, relative to the size of the fetus, are of about the same diameter.

## Concept Is Untenable

Some might think that the placenta fails to enlarge as fast as the uterine wall space to which it is attached, but this entails the concept that all villi except the center ones are constantly being moved inward from their former site on the uterine wall. This would require so much decidual vascular disruption that it becomes untenable. The only other hypothesis possible is that *only those villi that are attached to the one fourth area of the uterine wall at any stage will eventuate into the mature placenta*. All villi outside of this area gradually will be detached and atrophy to help form a peripheral ring, which increases in width as more of the margin of the ex-

From the Department of Obstetrics and Gynecology, Medical College of Georgia.



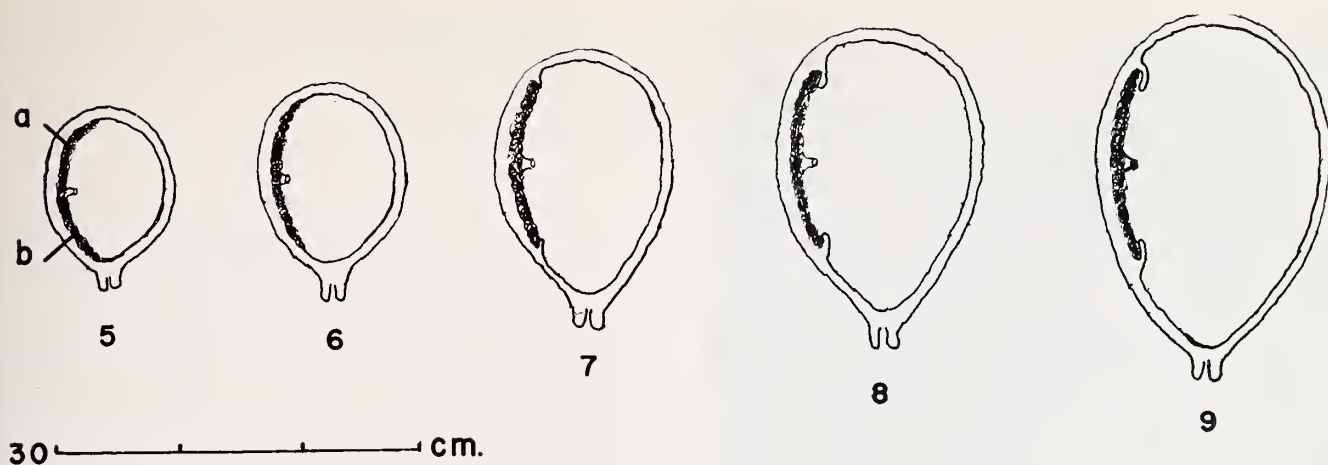


FIGURE 1

The postulated method of reduction in relative area of an early gestation placenta covering more than the optimal 20% or 25% of the sac wall. The margin of the placenta is gradually detached causing necrosis of the villi which are constantly added to the composition of the ring increasing its width. The numerals represent the months of gestation. From a to b on the illustration of the five month gestation sac denotes the portion that will compose the term discoid placenta.

cess placenta is separated, atrophied and added to the widening ring.

Almost all discoid placentas at term cover one fifth to one fourth of the area of the uterine cavity wall. Therefore, only this area of the uterine wall in any stage of pregnancy can take part in the production of the term placenta. All early excess area of the placenta must be gradually detached to form the

peripheral ring. One third of all term placentas have a marginate (or rarely a circumvallate) ring. As has been known for a hundred years, the ring is composed of necrotic and dehydrated villi, chorionic fibrous tissue, detached decidua and a variable amount of maternal blood. At its origin it lies on the extreme margin of the over-sized and immature placenta. Once begun, the overall inside diameter of

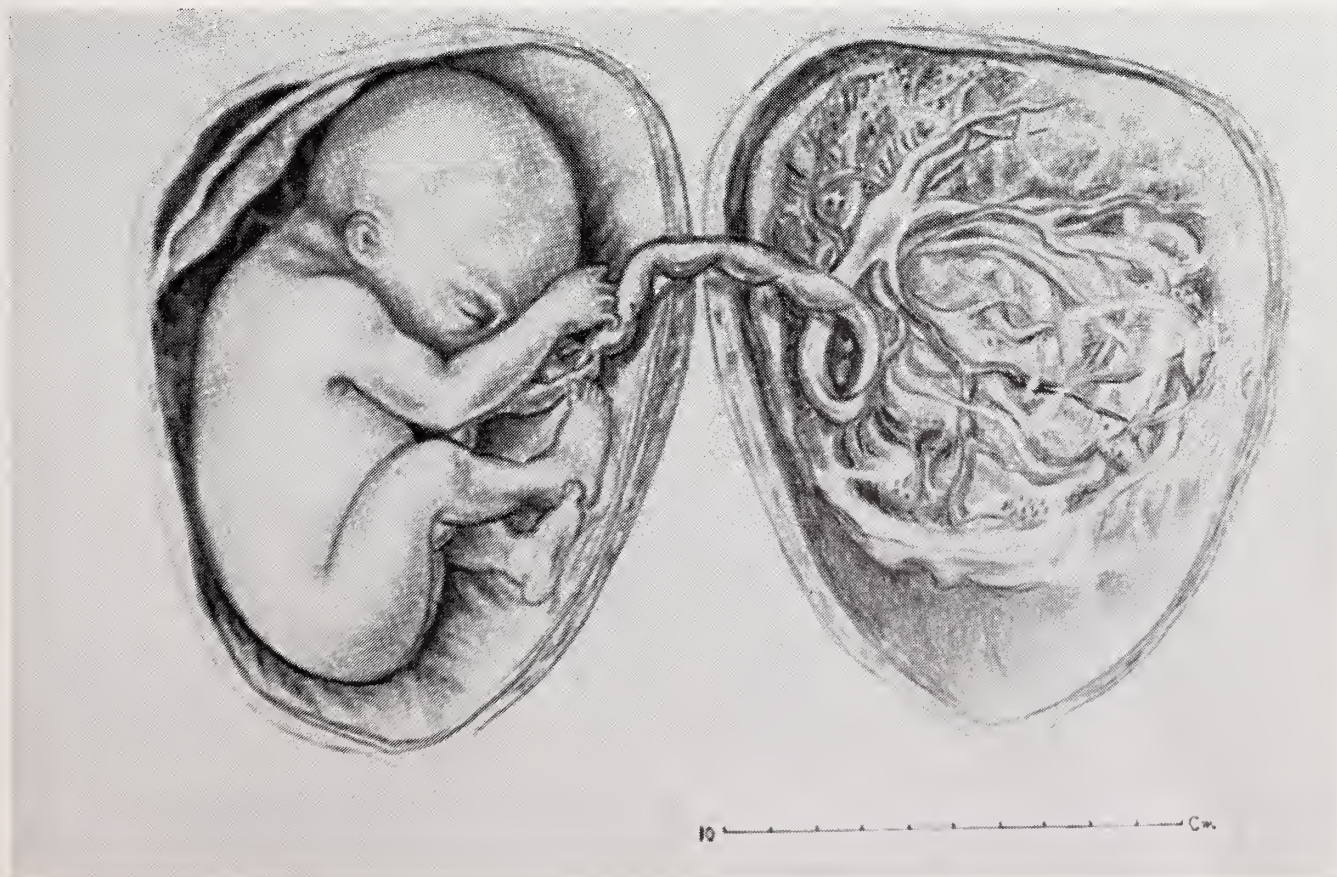


FIGURE 2

Five months pregnant uterus hardened in formalin prior to bisection into anterior and posterior segments. The placenta of early relatively extended area has already begun to reduce this by the development of a peripheral infarct ring.



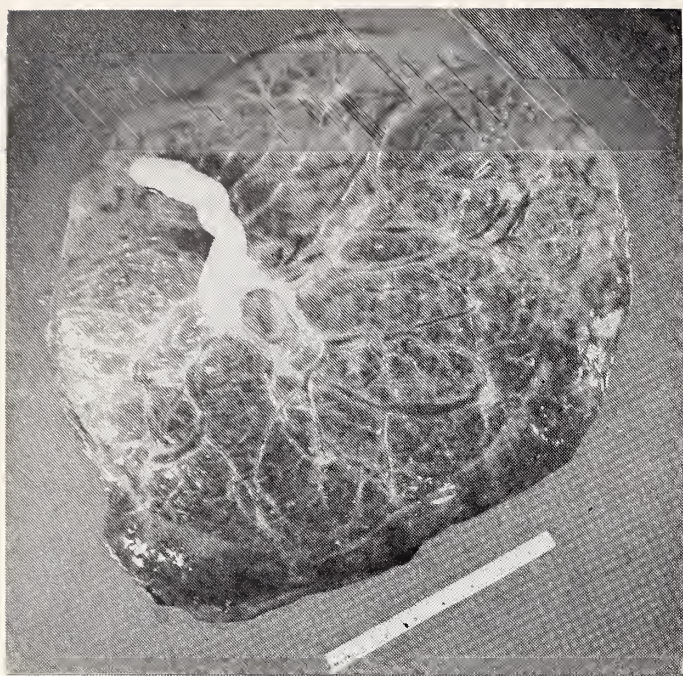


FIGURE 3

One third of all human placentas, at term, show in some degree the flattened and dehydrated ring in the form appearing in this placenta. The band may be partial or total, narrow or wide up to 15 or 20 mm.

the ring remains quite constant as the placenta of the true placental site increases in size. The fixed ring is then drawn anterior to the margin as the true placental area increases. In this manner an early-excess-area placenta is gradually reduced to the normal size at term.

Since there are free maternal blood cells incorporated in the composition of the ring, *it may be stated that the ring cannot be formed without peripheral decidual hemorrhage.* Consequently all placentas with peripheral rings are associated with pregnancies

in which there has been decidual hemorrhage. This hemorrhage is usually occult but, on occasion, may initiate enough peripheral separation of the placenta to irritate the uterus to contraction and abortion.

From 1870 to 1910 German and Italian students gave much study and speculation to these peripheral placental rings. However, during that time, human embryology was in its infancy and these students had no exact knowledge of how the fertilized human ovum attached to and developed in the decidua. Although there was minority dissension, these students finally more or less agreed that the implantation, especially in placenta circumvallata must be superficial so that the early implant was polypoid. This hypothesis, originated much earlier, was the one well presented by Robert Meyer, 1909<sup>1</sup> and later concurred with by J. Whitridge Williams, 1927.<sup>2</sup> The remainder of the world accepted this hypothesis, and it is the one presented in all American textbooks. However, this concept makes so little sense that the subject is less and less discussed and some of the latest editions give only a few lines to this common occurrence which truly involves the very foundation of the specialty.

This short paper is an attempt to reopen the matter and to present a hypothesis more in accordance with the observed facts and with due regard to the brilliant work on embryology produced at the Carnegie Institution of Washington in the past 50 years.

#### BIBLIOGRAPHY

1. Meyer, R.: Zur Anatomie und Entstehung der Placenta Marginata s. partim extrachorialis, *Arch. f. Gynaek. Berl.*, 89:542-573, 1909.
2. Williams, J. W.: Placenta Circumvallata, *Am. J. Obstet. & Gynec.*, 13:1, 1927.

## COLUMBUS' BRADLEY CENTER AWARDED FIVE-YEAR TRAINING PROGRAM GRANT

The Bradley Center, Inc. (a private, nonprofit center for psychiatric services, research, training, and consultation) has been awarded a grant from the Training and Manpower Resources Branch of the National Institute of Mental Health, Public Health Service. The grant is to cover a training program to be conducted over a five-year period and is for a total of \$186,265.

David S. Shapiro, Ph.D., Director of Training and Education at the Bradley Center, will serve as Program Director. Leonard T. Maholick, M.D., will serve as Co-Director. The Reverend Richard N. Robertson will serve as Pastoral Consultant.

The program aims to demonstrate that it is possible to train large numbers of physicians, ministers, nurses, caseworkers, school personnel, and others to serve as "mental health counselors" in communities which lack psychiatric and social service facilities. The program has certain unique features, among which are the following:

1. Training will be conducted in isolated communities within a radius of 200 miles of Columbus.

2. In each community in which the group works, it will provide special training for those professional people who show unusual interest and ability. When they have been trained, they will then go on to train other members of their profession under the group's supervision.

3. The method of training will consist of approximately 24 hours of intensive work devoted to teaching new, time-saving methods for collecting information about individuals seeking help, using the information assembled to help pinpoint the nature and severity of problems, and then teaching methods for planning case management which utilizes the existing skills of the community professionals.

4. The proposal is to involve between 300 and 400 professionals in this program over a period of five years.



# PSEUDOMONAS TOXEMIA OF BURNS

## Its Origin, Significance, and Control

H. Harlan Stone, M.D., *Atlanta*

DESPITE all of our modern advances, sepsis has remained the main cause of death in major burns. In particular *Pseudomonas* septicemia has been incriminated as the most frequent type of infection leading to a fatal septicemia. In these cases, the terminal event is typical of that associated with Gram-negative septicemia, yet in only one-third of the patients who die with *Pseudomonas* on the burn surface can the same bacterium be isolated from the blood. The remainder have blood that yields some other pathogen or, amazingly, have a sterile blood culture.

An explanation for this discrepancy between surface flora and blood culture has only recently become apparent. It has mainly evolved through an appreciation of the importance and lethal nature of *Pseudomonas* exotoxin.

Several laboratory investigations have led to a recognition of the toxic properties of the slime (capsular layer) produced by certain strains of *Pseudomonas aeruginosa*. Heat-stable and heat-labile hemolysins can initiate a sudden and severe hemolytic anemia. In addition, subcutaneous and intradermal injections have demonstrated the cytotoxic nature of the slime-layer factor. However, more important is the relative paralysis effected upon the reticulo-endothelial system. Such is manifested by leukopenia, inhibition of hemoglobin catabolism so that verdoglobin is excreted in the urine, significant delay of skin homograft rejection, and the presence of bacteria in the blood of many experimental animals although death has resulted from the administration of *Pseudomonas* exotoxin alone.

A parallel situation occurs in the burned human with a fatal sepsis. Considerable reduction in red cell mass may take place suddenly without obvious cause, often in conjunction with focal necrosis of granulation tissue or of areas adjacent to the burn (pyoderma gangrenosa). Leukopenia and verdoglobinuria may also be observed, as is the occasional long-term survival of homografts. In any event, these changes reflect the presence of *Pseudomonas* toxemia.

It should be remembered that some strains of *Pseudomonas aeruginosa* produce large amounts of toxin, while others produce little or none at all. How-

ever, the accidental discovery of verdoglobinuria has provided a method for determining the presence of toxemia. Although the detection of this pigment in the urine does not definitely establish a diagnosis of septicemia, it is a reliable sign of a situation that may terminate fatally in a severe toxemia or true septicemia.

Specific treatment must be directed toward elimination or reduction of the amount of toxin produced and thereby absorbed. Whenever the diagnosis of *Pseudomonas* toxemia is made, whether it is associated with septicemia or not, curtailment of toxemia can only be achieved by debridement of all necrotic tissue, application of an effective topical antibiotic (such as Gentamicin ointment which has proved the most efficacious of all), and early closure of the wound with viable skin (no matter whether it be autografts, homografts, or both). In addition, to protect against vascular invasion of pathogenic bacteria during this relative paralysis of the host's defenses, systemic antibiotics is required. To date, more success has been obtained with intramuscular Gentamicin sulfate (Garamycin, Schering) than with any other antibiotic.

In a series of more than 1700 major burns in whom *Pseudomonas* toxemia developed in 50, the mortality of this one complication has been reduced from 100% to approximately 10%. Success has been achieved only through an appreciation of the lethal nature of *Pseudomonas* exotoxin, early diagnosis of the condition by repeated cultures and fluorescent testing of the urine for verdoglobin, and finally energetic wound care in conjunction with both topical and systemic administration of the experimental antibiotic, Gentamicin.

### REFERENCES

1. Graber, C. D.; H. H. Stone; L. Kolb, and J. D. Martin, Jr.: In Vitro Sensitivity of Bacterial Flora from Burned Patients to Gentamicin Sulfate; *Antimicrobial Agents and Chemotherapy*—1963:161-163 (1964).
2. Stone, H. H.; J. D. Martin, Jr., and C. D. Graber: Verdoglobinuria: An Ominous Sign of *Pseudomonas* Septicemia in Burns; *Ann. Surg.* 159:991-995 (1964).
3. Stone, H. H.: The Green Urine Syndrome; *Bull. Emory Univ. Clinic*: (March, 1964).
4. Stone, H. H.; J. D. Martin, Jr., and L. Kolb: The Mechanism and Treatment of Verdoglobinuria in *Pseudomonas* Sepsis; *Surg. Forum* XV:48-49 (1964).
5. Stone, H. H.; J. D. Martin, Jr.; W. E. Huger, and L. Kolb: Gentamicin Sulfate in the Treatment of *Pseudomonas* Sepsis in Burns; *Surg., Gyn., and Obstet.* 120:351-352 (1965).
6. Stone, H. H.; J. D. Martin, Jr., and L. Kolb: Experiences in the Use of Gentamicin Sulfate Ointment; *Antimicrobial Agents and Chemotherapy*—1964 (in press).

From the Joseph B. Whitehead Department of Surgery, Emory University School of Medicine.

This work was supported in part by grants from the John A. Hartford Foundation and the Schering Corporation.

## LOMOTIL *Pharmacologic Activity*

The significant pharmacologic actions of Lomotil are summarized as follows:

Evidence indicates that Lomotil acts directly on the intestinal musculature to inhibit excess peristalsis.

Lomotil is not known to inhibit nonpropulsive intestinal movements.

Roentgenograms demonstrate that this activity occurs within two hours after oral administration and persists for at least six hours.

Comparative studies in the rat show Lomotil to be more effective in inhibiting fecal excretion than either codeine or morphine.

Analgesic, anticholinergic, mydriatic and gastric secretory effects have not been significant.

Reduction of propulsive motility with Lomotil relieves spasm and cramping, allows physiologic absorption of fluid and reduces frequency of evacuations to provide prompt, symptomatic control of virtually all diarrheas.

# LOMOTIL<sup>®</sup>

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride ..... 2.5 mg.

(Warning: May be habit forming)

atropine sulfate ..... 0.025 mg.

tablets • liquid



**slows propulsion**



**relieves distress**



**stops diarrhea**



*Precautions:* Lomotil is an exempt narcotic preparation of very low addictive potential: more than three million prescriptions have now been written for Lomotil. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

*Side Effects:* Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

*Dosage:* For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses*, until diarrhea is controlled, are:

**Children:**

- 3 to 6 months—3 mg. ( $\frac{1}{2}$  tsp.\* t.i.d.)
- 6 to 12 months—4 mg. ( $\frac{1}{2}$  tsp. q.i.d.)
- 1 to 2 years—5 mg. ( $\frac{1}{2}$  tsp. 5 times daily)
- 2 to 5 years—6 mg. (1 tsp. t.i.d.)
- 5 to 8 years—8 mg. (1 tsp. q.i.d.)
- 8 to 12 years—10 mg. (1 tsp. 5 times daily)

**Adults:**

- 20 mg. (2 tsp. 5 times daily or
- 2 tablets 4 times daily)

*\*Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

**SEARLE**

*Research in the  
Service of Medicine*

# SMOKING HABITS AND HEALTH IN GEORGIA AND OTHER SOUTHERN STATES\*

E. Cuyler Hammond, Sc.D

A. H. Letton, M.D., *Atlanta*

■ The findings are in good agreement with  
previous prospective epidemiological studies.

THE GEORGIA DIVISION of the American Cancer Society, together with 28 other divisions, is cooperating in a prospective epidemiological study aimed at identifying factors related to the occurrence of cancer and other diseases. Smoking is one of many environmental factors included in the investigation and we have recently published findings on the subject during the first 34 months of follow-up.<sup>1</sup> In this

paper, we will present some of the findings in the Georgia segment of the study.

During the latter part of 1959 and early 1960, volunteer workers of the Georgia Division of the American Cancer Society enrolled 28,775 men and women, the mean date of enrollment being November 29, 1959. The study area encompasses 71 of the 159 counties in Georgia. Upon enrollment, each subject answered a detailed questionnaire covering factors such as family history, history of disease, physical complaints, education, occupational exposure, height, weight, exercise, diet and various habits. The subjects are traced once a year and are requested to fill out brief questionnaires once every two years. In the most recent completed follow-up, 96.78% of the subjects were traced through September 30, 1962. (The next follow-up was started October 1, 1963, and is still in progress.) When a death is reported, we request the Georgia Health Department to supply us with a copy of the death certificate; and when cancer is mentioned on a death certificate, we request the doctor to supply additional information.

The Georgia portion of the report is confined to the records of 10,458 men between the ages of 40 and 89 who were traced through September 30, 1962. Of these 10,458 men, 581 (5.6%) were reported to have died; and we now have copies of the death certificate on 535 of them. Cancer was mentioned on 90 of the certificates and doctors have provided additional information on 78% of them.

A list of various physical complaints was printed on the first questionnaire and the subject was asked to check "yes" or "no" after each of them to indi-

TABLE I

PHYSICAL COMPLAINTS REPORTED BY 3,302 GEORGIA MEN WHO SMOKED 20 OR MORE CIGARETTES PER DAY AND BY 2,188 GEORGIA MEN WHO NEVER SMOKED REGULARLY

Physical complaint	Cigarette smokers with complaints		Non-Smokers with complaint		Ratio (b) + (c) (d)
	No. of Men (a)	% (b)	% (c)		
Cough (slight, moderate, severe) . . . . .	1,957	59.3	18.9		3.14
Cough (moderate or severe) . . . . .	960	29.1	5.4		5.39
Shortness of breath (slight, moderate or severe) . . . . .	1,184	35.9	17.5		2.05
Shortness of breath (moderate or severe) . . . . .	535	16.2	5.5		2.95
Pain or discomfort in chest (slight, moderate or severe) . . . . .	661	20.0	14.5		1.38
Pain or discomfort in chest (moderate or severe) . . . . .	260	7.9	5.1		1.55
Loss of appetite . . . . .	298	9.0	3.4		2.65
Loss of weight . . . . .	242	7.3	5.0		1.46
Gain of weight . . . . .	160	4.8	3.9		1.23
Fatigue easily . . . . .	1,304	39.5	25.2		1.57
Pain in stomach . . . . .	572	17.3	13.4		1.29
Indigestion . . . . .	1,222	37.0	29.9		1.24

\*From the Georgia Division of the American Cancer Society and the Statistical Research Section of the Medical Affairs Department of the American Cancer Society, Inc.



cate whether or not he had the complaint "at present." Those who had a complaint were asked whether it was "slight," "moderate" or "severe." Of the 10,458 men between the ages of 40 and 89, 3,302 said that they were currently smoking 20 or more cigarettes a day and 2,188 said that they had never smoked regularly. Table 1 shows the number and percent of these smokers who reported having various complaints and the percent of non-smokers who reported having the complaints. The percentages for the non-smokers have been adjusted to the age distribution of the cigarette smokers (this being necessary for comparability since the non-smokers tended to be older than the cigarette smokers).

Cough, shortness of breath and pain or discomfort in chest were all reported far more frequently by the cigarette smokers than by the non-smokers, the ratio being 3.14 to 1 for cough, 2.05 to 1 for shortness of breath and 1.38 to 1 for pain or discomfort in chest. Considering only subjects who reported these complaints to a moderate or severe degree, the ratios were 5.39 to 1 for cough, 2.95 to 1 for shortness of breath and 1.55 to 1 for pain or discomfort in chest. These findings are consistent with findings in histologic studies of changes in lung tissue in relation to cigarette smoking.<sup>2, 3</sup> Such studies have shown a high degree of association between cigarette smoking and: 1) hyperplasia and the occurrence of cells with atypical nuclei in bronchial epithelium 2) hyperactive glands in the walls of bronchial tubes and 3) changes in the lung parenchyma including rupturing of alveolar septums, fibrosis and thickening of the walls of arterioles and small arteries.

Loss of appetite was reported nearly three times as frequently by cigarette smokers as by non-smokers. One might expect this to be associated with loss of weight; and loss of weight during the preceding two years was reported somewhat more frequently by cigarette smokers than by non-smokers. However, gain of weight was also reported somewhat more frequently by cigarette smokers than by non-smokers. This suggests that fluctuations in weight may occur somewhat more frequently in cigarette smokers than in non-smokers.

A number of other physical complaints such as pain in stomach, indigestion, and a tendency to "fatigue easily" were also reported somewhat more frequently by cigarette smokers than by non-smokers. The picture in general indicates that cigarette smokers, as a group, tend to feel less physically fit than do non-smokers.

Hospitalization

At the time of the second follow-up (approximately two years after the start of the study) surviving subjects were requested to fill out a second

questionnaire. On this questionnaire, they were asked whether or not they had been hospitalized since October 1, 1959 (the date the study was started). Of course, non-survivors did not fill out these questionnaires; but we assumed that all those who died had been hospitalized prior to death, this being true in the great majority of cases.

In Table II, Georgia men aged 40 to 69 are classified in groups by their smoking habits as reported on the first questionnaire; and the percent hospitalized is shown for each of these groups. For comparability, the percentages have been standardized for age on the basis of the age distribution of all the men in the study.

Only 17.7% of the men who never smoked were hospitalized within two years while 23.8% of the men with a history of only cigarette smoking were hospitalized during the same period of time. Among current cigarette smokers, the risk of hospitalization increased with amount of smoking from 23.6% for those who smoked 1 to 9 cigarettes per day to 25.5% for those who smoked 20 or more cigarettes per day. The percent of men hospitalized was greater among cigarette smokers who said that they inhaled deeply than among those who said that they did not inhale or inhaled only slightly; and was greater among men who started to smoke cigarettes early in life than among those who started to smoke later in life.

A statistically meaningful analysis of death rates in relation to smoking habits requires a large number of subjects. Therefore, we combined the Georgia seg-

TABLE II  
PERCENT OF MEN HOSPITALIZED BETWEEN START OF STUDY AND SECOND FOLLOW-UP (APPROXIMATELY 2 YEARS), GEORGIA MEN AGED 40-69 AT START OF STUDY. PERCENTAGES ARE STANDARDIZED FOR AGE ON THE TOTAL POPULATION OF ENROLLEES IN THE STATE.

Smoking Habits	Percent Hospitalized
Never Smoked Regularly .....	17.7
Cigar, Pipe (no cigarettes) .....	17.8
Cigarette and other .....	20.4
Cigarette only .....	23.8
Current Cigarette* .....	25.4
1-9 a day .....	23.6
10-19 a day .....	24.9
20+ a day .....	25.5
Inhale none or slightly .....	22.5
Inhale moderately .....	25.3
Inhale deeply .....	29.1
Age Began Smoking:	
20 or older .....	23.4
15-19 .....	25.7
Before age 15 .....	29.6

\* Men with a history of only cigarette smoking who were currently smoking cigarettes at the time of enrollment.

TABLE III  
GEORGIA AND OTHER SOUTHERN STATES  
MORTALITY BY TYPE OF SMOKING (LIFETIME HISTORY)

Type of Smoking (Lifetime History)	No. of Men	Age 40-69 No. of Deaths		Mortality Ratio	No. of Men	Age 70-89 No. of Deaths		Mortality Ratio
		Obs.	Exp.			Obs.	Exp.	
Never Smoked Regularly .....	15,203	395	395.0	1.00	2,757	446	446.0	1.00
Pipe, Cigar Only .....	8,573	299	251.0	1.19	1,843	304	295.3	1.03
Cigarette and Other .....	16,265	603	404.5	1.49	1,451	244	209.5	1.16
Cigarette Only .....	39,999	1,639	871.1	1.88	2,119	407	299.2	1.36
Total .....	80,040	2,936	1,921.6	1.53	8,170	1,401	1,250.0	1.12

ment of the study with the segment from those of other southern states, Mississippi, Louisiana, Texas, Tennessee, Virginia, North Carolina, South Carolina and Florida. In these nine states we enrolled and traced a total of 88,210 men in age group 40-89; and 4,337 of these died between the start of the study and September 30, 1962.

Table III shows the men classified by type of smoking (lifetime history). The figures under the heading "observed" are the actual number of deaths reported from the start of the study through September 30, 1962. Figures under the heading "expected" are the number of deaths which would have occurred if the age-specific death rates in each group had been the same as the age-specific death rates of men who never smoked regularly. In other words, the age-specific death rate of the non-smokers is taken as a standard for comparison. The mortality ratio is the observed number of deaths divided by the expected number of deaths. By definition, the mortality ratio of the non-smokers is 1.00.

Men with a history of only cigarette smoking had by far the highest death rates (as indicated by their

high mortality ratios). In age group 40 to 69, the death rate of such cigarette smokers was 88% higher than the death rate of non-smokers; and in age group 70-89 the death rate of such cigarette smokers was 33% higher than the death rate of non-smokers. (See Figure 1.)

The death rate of men who smoked cigarettes and also smoked pipes or cigars (i.e. the "cigarette and other" group) was somewhat lower than the death rate of men who smoked cigarettes only. This is accounted for by the fact that men with mixed smoking habits tend to smoke fewer cigarettes per day and tend to inhale the smoke less deeply than do men who smoke only cigarettes.

The death rate of pipe and cigar smokers was only slightly higher than the death rate of non-smokers. This appears to be due to the fact that the great majority of pipe and cigar smokers do not inhale the smoke or inhale it only to a slight degree.

Table IV shows further details on current cigarette smokers (i.e. men who were smoking cigarettes regularly at the time they enrolled in the study) with a history of only cigarette smoking. It is confined to men between the ages of 40 and 69 for the reason that there were relatively few such cigarette smokers among men in the older age groups. Figures for non-smokers are included to give a basis for comparison.

The mortality ratio increased substantially with the number of cigarettes smoked per day and was substantially higher among cigarette smokers who said that they inhaled the smoke deeply than among those who said that they did not inhale the smoke or inhaled only slightly. The cigarette smokers who took up the habit before they reached their 20th birthday had higher death rates than did cigarette smokers who started the habit later in life.

Death certificates indicated that coronary artery disease accounted for 1,769 (40.8%) of the 4,337 deaths. Deaths from this cause were highly associated with the smoking habits of men in age group 40 to 69 but less highly associated with the smoking habits of men in age group 70 to 89. In age group

TABLE IV  
GEORGIA AND OTHER SOUTHERN STATES  
MORTALITY BY AMOUNT OF CIGARETTE SMOKING, DEGREE  
OF INHALATION AND AGE BEGAN CIGARETTE  
SMOKING. AGE GROUP 40 TO 69.

Current Cigarette Smoking	No. of Men	No. of Deaths Obs.	Deaths Exp.	Mortality Ratio
Cigarettes per Day:				
1-9 .....	2,260	95	55.2	1.72
10-19 .....	5,030	240	115.8	2.07
20-39 .....	18,020	756	361.3	2.09
40+ .....	4,431	172	80.7	2.13
Degree of Inhalation:				
None or slight .....	6,204	270	162.8	1.66
Moderate .....	16,332	681	325.7	2.09
Deep .....	7,175	314	134.0	2.34
Age Began Cigarette Smoking:				
25+ .....	2,304	76	56.4	1.35
20-24 .....	6,597	242	136.1	1.78
15-19 .....	15,653	694	307.3	2.26
<15 .....	4,012	194	86.3	2.25
Never Smoked Regularly ..	15,203	395	395.0	1.00



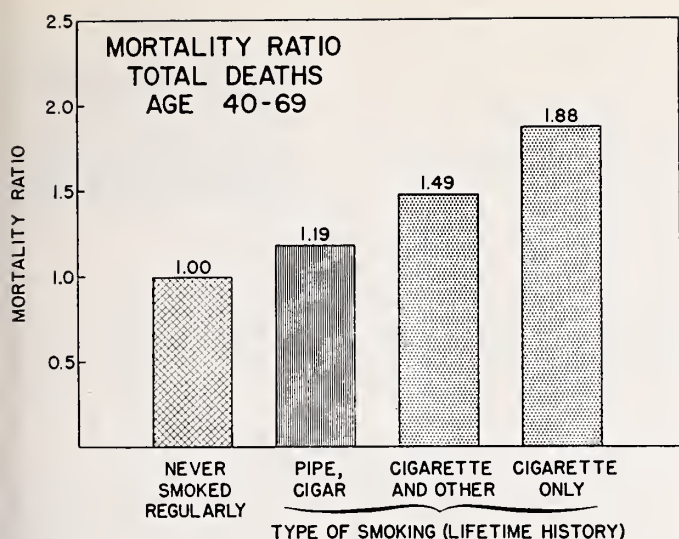


FIGURE 1

40-69, the coronary artery disease mortality ratios were: 1.00 for men who never smoked, 1.20 for pipe and cigar smokers, 1.68 for men who smoked cigarettes and also smoked pipes or cigars and 2.03 for men who smoked only cigarettes. The corresponding mortality ratios for men in age group 70-89 were 1.00, 1.05, 1.20 and 1.37 respectively. Among cigarette smokers, the death rate from coronary artery disease was related to the degree of inhalation. For example, among cigarette smokers in age group 40-69, the mortality ratio was 1.76 for those who said they did not inhale the smoke or inhaled slightly and 2.69 for those who said that they inhaled deeply.

Lung cancer accounted for the death of 201 men (171 in age group 40-69 and 30 in age group 70-89). All but 11 of these men were smokers (10 smoked only pipe or cigars and 180 had a history of regular cigarette smoking). The lung cancer death rate was 5½ times as high among men with a history of cigarette smoking as among men who never smoked; and the lung cancer death rates of cigarette smokers increased greatly with amount of smoking.

Previous studies have shown a relationship between smoking habits and death rates from cancer of the buccal cavity, pharynx, larynx, esophagus and bladder. Cancer of these sites accounted for 58 deaths. All but ten of these men were smokers (eight smoked only pipes or cigars, five smoked cigarettes and pipes and 35 smoked only cigarettes).

Emphysema was responsible for 69 deaths. Two of these men had never smoked regularly, one smoked only pipes or cigars and 66 had a history of cigarette smoking.

### Conclusions

The findings in the study on men in Georgia and other southern states, are in good agreement with previous prospective epidemiological studies on

smoking in relation to health.<sup>4-9</sup> Hospitalization from all causes increased from 17.7% of non smokers to 25.5% for those smoking 20 or more cigarettes daily. The death rate from all causes was increased 88% in the 40 to 69 yr. age group and 77% in the 70 to 89 yr. group. Coronary heart disease was increased 203% for men smoking cigarettes only. Lung cancer death rate was 5½ times as high among smokers. The epidemiological evidence together with evidence from clinical, histologic, and experimental studies indicate that cigarette smoking is a serious hazard to health.<sup>10, 11, 12</sup>

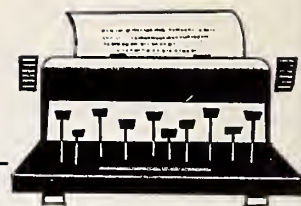
### Acknowledgements

This study was made possible by the cooperation of the men who volunteered as subjects; volunteer workers of the American Cancer Society who enrolled and traced the subjects; the Health Departments of Georgia and the other southern states that provided copies of death certificates, and many physicians who provided additional information relating to deaths from cancer.

340 Boulevard, N.E.

### REFERENCES

1. Hammond, E. C.: Smoking in relation to mortality and morbidity. Findings in first thirty-four months of follow-up in a prospective study started in 1959. *J. Nat. Cancer Inst.* 32:1161-1188, 1964.
2. Auerbach, O.; Stout, A. P.; Hammond, E. C., and Garfinkel, L.: Changes in bronchial epithelium in relation to cigarette smoking and in relation to lung cancer. *New Eng. J. Med.* 265:253-267, 1961.
3. Auerbach, O.; Stout, A. P.; Hammond, E. C., and Garfinkel, L.: Smoking habits and age in relation to pulmonary changes: rupture of alveolar septums, fibrosis, and thickening of walls of small arteries and arterioles. *New Eng. J. Med.* 269:1045-1054, 1963.
4. Doll, R. and Hill, A. B.: Lung cancer and other causes of death in relation to smoking; second report on mortality of British doctors. *Brit. Med. J.* 2:1071-1081, 1956.
5. Hammond, E. C. and Horn, D.: Smoking and death rates—report on 44 months of followup of 187,783 men. Part I. Total mortality. Part II. Death rates by cause. *J.A.M.A.* 166:1159-1172; 1294-1308, 1958.
6. Dorn, H.: Tobacco consumption and mortality from cancer and other diseases. *Public Health Rep.* 74:581-593, 1959.
7. Dunn, J. E., Jr.; Linden, G., and Breslow, L.: Lung cancer mortality experience of men in certain occupations in California. *Amer. J. Public Health* 50:1475-1487, 1960.
8. Best, E. W. R.; Josie, G. H., and Walker, C. B.: A Canadian study of mortality in relation to smoking habits, a preliminary report. *Canad. J. Public Health* 52:99-106, 1961.
9. Doyle, J. T.; Dawber, T. R.; Kannel, W. B.; Heslin, A. S., and Kahn, H. A.: Cigarette smoking and coronary heart disease. Combined experience of the Albany and Framingham studies. *New Eng. J. Med.* 26:796-801, 1962.
10. Hammond, E. C.: The effects of smoking. *Scientific American* 207:39-51, 1962.
11. American Cancer Society: Cigarette smoking and cancer. The evidences upon which the American Cancer Society's position and programs are based. New York, American Cancer Society, 26 pp. 1963.
12. U. S. Department of Health, Education and Welfare: Smoking and health, report of the Advisory Committee to the Surgeon General of the Public Health Service. Public Health Service publication No. 1103, Washington, D. C., 1963.



## Richard Torpin and Placentation

SINCE 1936 and through a procession of 1,000 students at the University of Georgia Medical School at Augusta, Dr. Richard Torpin has nurtured and professed his concepts of the exacting science of obstetrics, particularly the theories of placentation and placental physiology. He has shown a singleness of purpose and an ingenuity not commonly seen even in professional ranks. He has been called an innovator but in a complimentary sense, for he has had provocative ideas for instruments and demonstration techniques.

His theories of the placental behavior have not been universally accepted, but this is not too unusual, because the medical profession, by tradition, is naturally skeptical and cynical. This is the way it should be, and eventually these theories will stand

or fall on their merit, being tested by time.

It is believed by many of Dr. Torpin's students and audience that his concepts are very sound fundamentally and will stand firm in the test of time. Those that have listened to his teachings, observed his demonstrations and noted his inextinguishable enthusiasm could not help but be impressed by his profound thinking and dedication.

Whether or not these ideas will be universally accepted is not the point—the real point is that the minds of a generation of obstetricians and gynecologists have been positively stimulated to think analytically about one of the most intriguing and least understood phenomena in medicine.

*1211 West Peachtree Street, N.E.  
Atlanta, Georgia 30309*

## AMA Annual Meeting Highlights

WHILE THE AMA House of Delegates meeting, held recently in New York City, had one eye on "medicare" legislation pending in Washington, there were many other actions by the House noteworthy of review. In assessing the business of the House, the Georgia Delegation consisted of our four Delegates, their four Alternate Delegates, the MAG President, President-elect and Secretary. The MAG delegation conducted two caucus meetings during the session and was in attendance at all House Reference Committee hearings. A brief résumé of major actions follows.

*AMA Group Disability Insurance Program*—The House noted that the AMA Group Disability Insurance Program may quite probably be, to quote the carrier, "in serious trouble" financially. The carrier has indicated that it will not continue the present contract beyond the present guarantee period of August 31, 1967. Therefore, the House stipulated

that all prospective applicants must be advised of the fact in promotional and sales materials regarding the program. Further, the House called for a full report of the status of the program be made to the membership. And finally, the House recommended that during the balance of the term of the present contract, the AMA Board of Trustees study the existing contract to determine what, if any, revisions are necessary to provide an actuarially sound disability insurance program for the membership—and so report back to the House before the present contract expires.

*Physician Representation on Areawide Hospital Planning Agencies*—The House strongly urged that physician representatives of appropriate county medical societies be active members of all areawide hospital planning agencies. It was emphasized that adequate physician representation can only be assured if physician members are appointed from a list of



nominees recommended by the county society involved in the jurisdiction of the planning agency.

*Physician Reimbursement in Public Supported Medical Programs*—The House recommended that when government assumes financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care. Therefore, reimbursement for the services of physicians participating in government supported programs should be on the basis of usual and customary fees.

*Practice of Radiology in Hospitals*—The House reaffirmed the policy previously established by the AMA concerning the practice of radiology, pathology, anesthesiology and physical medicine in relation to hospitals and recommended that these specialty groups be strongly encouraged to effect these principles for their members and that medical staffs, state and component medical societies be urged to implement the policy of AMA on physician-hospital relations by all appropriate means.

*Courtesy Privileges to Physicians and Their Dependents*—While a more extensive study of courtesy privileges is being conducted by the AMA Judicial Council to provide further guidance to the profession on this matter, the House recommended that physicians should be encouraged to secure voluntary health coverage for themselves and their dependents and to tender any insurance benefits when received to the attending physician when appropriate.

*DeBakey Commission Report*—The House adopted the following statement: The AMA points with pride to the immense strides made in the approaches to the conquest of heart disease, cancer and stroke under existing patterns of research and medical practice; strongly favoring the use of available financial support for extension of these patterns rather than replacement by a complex of medical control centers and satellites. The AMA opposes those particular Commission recommendations which call for and have stimulated proposals for hastily contrived and unproven sweeping changes in the pattern of medical research, education and patient care.

*American Board of Family Practice*—The House disapproved a series of resolutions urging the approval of an American Board of Family Practice because it was felt that these resolutions would circumvent existing procedures for initiating examining boards as expressed in the Essentials for Approval of Examining Boards in Medical Specialties.

*AMPAC & GaMPAC Voluntary Contribution*—The House reaffirmed its previous position and urged all state and county medical societies to approve, where feasible, the inclusion of a voluntary, non-deductible contribution to AMPAC & GaMPAC in the society's annual billing statement.

*Pending "Medicare" Legislation*—The most controversial issue before the House was that of non-participation under any so-called "medicare" law that might be passed by Congress. The House recommended that "the members of the AMA be reminded that it is each individual physician's obligation to decide for himself whether the conditions of a case for which he is about to accept responsibility permit him to provide his own highest quality of medical care."

### A Pledge

In adopting a substitute resolution, the House declared that "the physicians of the United States of America pledge themselves to continue their search and activity, in whatever social environ may develop, to secure or to restore the freedom, high quality and availability of medical care which has been traditional in our country."

The House further stated that "When the fate of the pending medicare legislation is determined, this House will review, in special session if necessary, the effect of the law and take whatever action is deemed necessary."

This brief summary is not intended to serve as a detailed report of all the actions taken by the AMA House at their June 20-24, 1965, New York City Annual Session—but complete data on these and other items considered by the House at this session may be obtained from MAG Headquarters Office on request.

## WHAT DO YOU WANT TO KNOW ABOUT DRUGS?

In my opinion, the pharmaceutical manufacturers have many opportunities to win the good-will and understanding of the medical profession. One of these opportunities, for example, pertains to the present dispute over the reporting of adverse side effects in journal ads and on drug labels. It seems to me that the industry has a point when it objects to excessive restrictions and argues that the medical profession receives adequate in-

formation about drugs through many channels now available. However, I believe that it could do a better educational job than it is presently doing, because many of my colleagues are still not convinced. For the future of medical practice let's try to get to know each other better.—William L. Wheeler, Jr., M.D., in *Experimental Medicine and Surgery*, 22:2-3, (June-Sept.) 1964.





## THE AMA ANNUAL SESSION

TO THOSE OF YOU who have never attended a meeting of the AMA, I would like to say that you should make an effort to do so. You will find it to be a most interesting and educational experience. I have just returned from the New York meeting of June 20-24, which gives me a score of three Annual Sessions and one Clinical Session. This New York Session had a record number of physicians to register—24,268. The New York Coliseum housed the meetings of the 22 Scientific Sections where a total of 631 papers made up the program. The Coliseum also housed on four floors the splendid scientific exhibits and the 243 technical or commercial exhibits. To visit and really do justice to all these exhibits could consume the entire time of the session.

Returning to the Americana from the Coliseum one day, we found the hotel entrance virtually blocked by 75 to 100 placard-carrying, chanting pickets. These people were elderly or crippled, or afflicted in other ways. It was necessary for your President-Elect and me to cross the picket line, which we did without incident. Those people were really pitiful and we could not help but feel that they were being "used" for their sympathy value. Needless to say, the picketing had no effect on the actions of the House of Delegates.

The House of Delegates, meeting at the Americana, held its opening session Sunday afternoon, June 20, at which time Dr. James Z. Appel of Lancaster, Pennsylvania, was inaugurated as 1965-66 AMA President. This was indeed an impressive ceremony. Seated on the platform, in addition to the AMA officers, were the Presidents of many foreign Medical Societies, as well as the National Presidents of many of our allied organizations, backed up by the Presidents of all our State and territorial Medical Societies. I almost wished that I could have been sitting out front in order to get the full impressive effect of this important function.

Dr. Appel in his inaugural address stated that regardless of personal opinion, "We do not have the right—either as physicians or citizens—to violate a law or to violate the spirit of the law or its intent." He further brought out that any organized non-participation would be in violation of the spirit and in-

## PRESIDENT'S LETTER

tent and could well result in more restrictive and punitive legislation.

Despite Dr. Appel's position, the subject of non-participation was brought up in various ways in nine resolutions. The Reference Committee considering these nine resolutions and that portion of Dr. Appel's speech held hearings all Monday afternoon and Tuesday morning. 800 people attended and 80 spoke before this Committee. The Committee went into executive session Tuesday afternoon and was unable to make its report available until about noon Wednesday. Then on Thursday morning, most of the time was spent by the House in considering the Committee's report and the various amendments, amendments to amendments and substitutes. In consideration of all the above, the House recommended that—"the members of the American Medical Association be reminded that it is each individual physician's obligation to decide for himself whether the conditions of a case for which he is about to accept responsibility permit him to provide his own highest quality of medical care."

The House declared in a substitute resolution that, "the physicians of the United States of America pledge themselves to continue their search and activity in whatever social environment may develop to secure or to restore the freedom, high quality, and availability of medical care which has been traditional in our country. When the fate of the pending medicare legislation is determined, this House will review, in special session if necessary, the effect of the law and take whatever action is deemed necessary."

On Thursday morning the new officers of the American Medical Association were elected by the House. Dr. Charles L. Hudson, a Cleveland, Ohio, internist, was named 1965-66 President-Elect. Dr. Hudson has been a member of the AMA Board of Trustees since 1961. He has held many other positions of responsibility in both medical education and in organized medicine. I was most favorably impressed by him and feel that his choice was an excellent one.

All of the foregoing necessarily just covers some of the highlights. To do more would require more space than is allotted this letter. You should begin now to plan for the Clinical Session in Philadelphia late this year. Then you can really see for yourself what an AMA meeting is like.

George H. Alexander, M.D.  
President, Medical Association of Georgia





## AORTO-ILIAC OCCLUSIVE DISEASE

Douglass G. Whitney, M.D., *Atlanta*

**T**HE PATIENT with isolated arteriosclerotic narrowing or obliteration of the terminal aorta and iliac arteries presents a distinct clinical entity, as originally described by Leriche. He is readily diagnosed clinically, and today may expect surgical correction with mortality, morbidity and prognosis comparable to the patient undergoing gastrectomy for intractable duodenal ulcer.

When combined with associated arterial disease, admittedly the problem becomes more complex, but there remains a majority of patients who will benefit significantly from timely aorto-iliac disobstruction alone. In order to clarify early recognition, methods in clinical diagnosis, and therapeutic measures available today, there follows what is hoped will be a helpful outline.

### Clinical Diagnosis

Terminal aortic and iliac artery occlusive disease occurs at the mean age of 50 years, but may be seen as early as the age of 30, a full decade earlier than systemic arteriosclerosis. This fact, plus its tendency to occur as an isolated lesion, provides the surgeon with a potential for excellent prolonged rehabilitation.

Even though these arteries are not accessible to palpation or adequate auscultation, an exact anatomic diagnosis may be made clinically. Intermittent claudication is usually the earliest symptom, and when combined with a decreased or absent femoral pulse, implies aorto-iliac occlusive pathology. Further localization of the lesion is made possible by the absence of buttock claudication with external iliac artery lesions and by its presence in common iliac artery pathology. Since the terminal aorta is almost never involved as an isolated lesion, that is, without common iliac artery involvement, it follows that the site of occlusive pathology may become clear by history alone. Symptoms of diminishing libido, difficulty with erection, etc. are supportive but of no great diagnostic importance.

In pure aorto-iliac occlusive disease, that is without femoral, popliteal or small vessel disease, the appearance of the legs is normal without hair loss, trophic skin, or temperature change, even with com-

plete aortic occlusion. However, with the increasing frequency of associated arterial blocks in series, one may expect to observe these changes. A helpful rule of thumb correlating the number of significant arterial blocks with physical findings is as follows: a single arterial block, such as common iliac artery occlusion, produces at the most, intermittent claudication as already outlined. Two arterial blocks in series, such as common iliac and superficial femoral artery occlusion, usually result in pain of that foot supplied, at rest. Whereas three arterial blocks, as with common iliac, superficial femoral, and popliteal artery occlusion in series results inevitably in gangrene of some portion of the foot supplied. Since small vessel disease alone may result in gangrene, the degree of involvement of these vessels must be recognized, for the above postulate to be helpful. This may be accurately judged by skin changes of atrophy, hair loss, nail deterioration, and dependent rubor of the foot.

When one femoral pulse is questionably diminished with respect to the other, the delay of pulse timing may be detected by simultaneous palpation. It should be made clear that a full femoral pulse may be present even with 70%-80% iliac arterial narrowing, and this finding does not therefore rule out significant pathology in a patient complaining of intermittent claudication. It may occasionally be noticed in such patients that, after exercise, a previously full pulse will be undetectable. This is commonly known as the phenomenon of disappearing pulses and a thorough understanding of hemodynamics is necessary for its interpretation. On the other hand, a palpable pulse may exist distal to a complete iliac artery occlusion, as supplied by collateral flow, and consequently a weak pulse does not always mean large vessel continuity.

### To Assess Clinically

Armed with the above tools in diagnosis, when confronted with a patient with absent femoral pulses, it may be possible to accurately assess the distal arterial tree clinically, a prerequisite for arterial reconstruction.

Clinical diagnosis should always be supplemented

by arteriography, even when surgery is not entertained in therapy. Translumbal aortography with a seven inch, 17 gauge needle, under local or general anesthesia, with 30 cubic centimeters of Angioconray is the preferred method of study and may be accomplished with less risk of limb or life than that of administering one unit of blood. The nonoperative candidate may well benefit from an arteriogram which delineates his pathology for reference on the day he may develop sudden gangrene of one foot.

### **Surgery**

Surgical correction in 1965 carries an expected mortality of 2%-3%, with loss of limb directly at-

tributable to surgery in less than 2% of cases. It follows, therefore, that greater than 95% of patients will benefit from re-establishment of blood flow continuity.

The surgical procedures selected and techniques employed vary in refinement from surgeon to surgeon. However, among those acceptable are endarterectomy, endarterectomy with vein patch closure, aorto-iliac and aorto-femoral prosthetic bypass grafting, each with or without lumbar sympathectomy. The operation should be individualized to suit not only the patient's lesion and operative risk, but also the operating surgeon's ability.

340 Boulevard, N.E.

*Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.*

## **YERKES ANIMALS OCCUPY NEW QUARTERS AT EMORY UNIVERSITY**

The most valuable collection of non-human primates anywhere in the world was recently moved to the new \$1,873,963 quarters of the Yerkes Regional Primate Research Center on the Emory campus in suburban Atlanta in July.

The animals were moved from Orange Park, Florida, to Emory, a distance of 340 miles, in a specially equipped van. Four loads were necessary.

More than 100 great apes (gorillas, chimpanzees and orangutans) and nearly 200 monkeys were moved.

Market value of the animals transferred is estimated at close to a quarter of a million dollars. Their intrinsic worth is a great deal more. Many of the chimpanzees (above 70) have been studied for untold hours. Records covering many years of study have been accumulated. The orangutans (about 25) cost about \$2,500 each and, since the animals are so scarce, could not be bought again at any price. It is the biggest orangutan colony in the world. The collection of gorillas (about 10) is worth \$50,000 and would be difficult to duplicate at the same price. The gorilla collection is probably the largest in any institution in the world. The entire collection is the most valuable—from both the monetary and scientific standpoints—in the world.

### **Additional Quarters**

In addition to the quarters on the Emory campus, the center also contains a 117-acre field station 25 miles northeast of the campus near Lawrenceville, Georgia. Most of the monkeys from Orange Park eventually will be placed at the field station. At first, however, they will be housed at the new center. A group of pigtail monkeys, used in studies of social behavior, will go directly to the field station. Most of the great apes will go directly to the center and remain there.

With the exception of a German scientist's collection of apes on the Canary Islands—a collection no longer existing—Yerkes was the first center established for non-human primate research. In 1924, its founder, the

late Dr. Robert M. Yerkes of Yale University, moved four chimpanzees into a remodeled barn-garage in New Haven, Conn. There he soon demonstrated that it was feasible to rear chimpanzees in captivity and practicable to use them in scientific research.

In the late 1920's Dr. Yerkes began to look for a permanent site for his primate laboratory, and he decided it should be in a more nearly tropical climate. A survey committee of eminent biologists endorsed the expansion and the Rockefeller Foundation, which had been supporting the scientist financially all along, appropriated additional funds to purchase the tract in Orange Park. Yale established the laboratories in Orange Park, with Dr. Yerkes as director, in 1930. Yale gave the laboratories to Emory in 1956.

### **A Grant for New Facilities**

A grant from the National Heart Institute financed the new facilities at Emory into which the animals have been moved. In addition to the animals transferred from Orange Park, some that have been housed in the basement of the Anatomy Building on the Emory Campus will also be moved to quarters in the new center. Among the primates already at Emory are a number that survived atomic blasts. They are presently housed in trailers.

The center will operate on funds from the Animal Resources Branch of the National Institutes of Health and from grants for individual research projects. Its annual budget will be nearly \$1,000,000 a year. When the move is completed, some 100 humans, including 27 scientists, will work with and care for animals at the center.

Since non-human primates are closest to man in the biological chain, primate research has shed light on many problems besetting mankind. Studies concerning heart and blood vessel disease, muscular dystrophy, and other disorders will be conducted at the center.





## RECORDING LICENSE

John L. Moore, Jr., *Atlanta*

**H**AVE YOU RECORDED your certificate from the State Board of Medical Examiners with the clerk of the superior court of the county in which you reside?

If not, please consider the implication of a decision by the Supreme Court of Mississippi in March, 1965.

### Mississippi Case

In Mississippi the statute provides that "every person who receives a license to practice medicine must file it in the office of the clerk of the circuit court of the county in which he resides within 60 days from the date of its issuance; otherwise it shall become void."

The physician in the case did not record his license within 60 days. The Supreme Court of Mississippi upheld the ruling of the State Board of Health enjoining the physician from practicing medicine until he obtained a new license.

The Mississippi court said that the statute was plain and unambiguous and therefore must be construed to mean what it said. The physician's license to practice medicine became void at the expiration of 60 days from its issuance and could not be restored to validity by a subsequent recordation.

### Georgia Statute

Georgia law says that "before any person who obtains a certificate from the Board of Medical Examiners may lawfully practice medicine and surgery, he shall cause the said certificate to be recorded in the office of the clerk of the superior court of the

county in which he resides." Further on, the statute says "each applicant receiving a certificate from the Board shall cause the same to be registered within 30 days."

The Georgia statute does not have the words as in the Mississippi statute "otherwise, it shall become void." However, it is perfectly possible that the Supreme Court of Georgia might say that that was the intent of the language "before any person who obtains a certificate may lawfully practice medicine and surgery, he shall cause the said certificate to be recorded, etc."

### Collecting Fees

Georgia cases have consistently refused to allow a physician to recover fees in court from patients if the physician had not recorded his license in the office of the clerk of the superior court of his county of residence. However, there has been no decision as to whether he would lose his license and have to apply for a new one and take the examinations given by the State Board of Medical Examiners again. It is possible that a court in Georgia would construe the Georgia statute in the same way as it was construed in the Mississippi case discussed above.

Why run this risk? Be sure that your certificate is properly recorded.

*Suite 1220*

*C & S Bank Building*

*The case commented on is Conway v. Mississippi State Board of Health, 173 So. 2d 412 (Miss. 1965).*

*Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.*

## NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

Asher, Harold  
Active—Fulton

340 Boulevard, N.E.  
Atlanta, Georgia 30312

Belcher, William T., Jr.  
Active—DeKalb

754 Michael Street, N.E.  
Atlanta, Georgia 30329

Boss, James L.  
Active—Carroll-Douglas-  
Haralson

Villa Rica, Georgia 30180

Futch, William A.  
Active—Newton-Rockdale

Conyers, Georgia 30207

Mitchell, James K., Jr.  
Active—Fulton

1293 Peachtree Street, N.E.  
Atlanta, Georgia

Rawls, William J.  
Active—DeKalb

1767 Haygood Drive, N.E.  
Atlanta, Georgia 30307

Reed, Ray D.  
Active—Floyd

Floyd Hospital  
Rome, Georgia

Shorter, Charles L.  
Active—Fulton

250 Auburn, N.E.  
Atlanta, Georgia

# THE ASSOCIATION



## DEATHS

HOWARD J. MORRISON, Savannah pediatrician and civic leader, died June 13, 1965, after an attack of illness in New Haven, Conn.

Dr. Morrison, 59, was in New Haven to attend the graduation of his son, Howard J. Morrison, Jr., from Yale University.

During several decades of practice here, Dr. Morrison was a leader in many fields, including the fight for construction of Memorial Hospital and the acceptance of polio vaccine.

A veteran traveler in Europe, Dr. Morrison spent much time analyzing the East German and Russian governments and their relationships to the United States.

Earlier this year he was re-elected president of the Hibernian Society of Savannah. He was advanced from the vice-presidency in 1964, succeeding John M. Brennan. He had been a member of the society since 1941.

A native of Savannah, Dr. Morrison was graduated from the University of Georgia Medical School in 1929. He did postgraduate training in several Chicago hospitals.

He was a fellow of the American Academy of Pediatrics and a licentiate of the American Board of Pediatrics. He had practiced pediatrics in Savannah since 1933, except for a tour of duty with the U. S. Navy during World War II.

He was a past president of the Georgia Medical Society and had been a vice president and member of the board of directors of the University of Georgia Alumni Society.

He was a member of St. Paul's Episcopal Church.

Surviving, besides his son, are his wife, Mrs. Mary Lane Morrison; another son, Mills Lane Morrison; a daughter, Miss Mary Morrison; his mother, Mrs. A. A. Morrison; two brothers, Joseph V. Morrison and Jack S. Morrison of Atlanta; and a sister, Miss Mary K. Morrison.

## SOCIETIES

Four new physicians have become members of the BIBB COUNTY MEDICAL SOCIETY, Macon.

They are Dr. Marcus Thomas, pediatrician, whose offices will be at 2009 Vineville Ave.; Dr. Mell Duggan, urologist, who will be associated with Dr. Ben Bashinski at 839 First St.; Dr. Spencer Maddox, ophthalmologist, who will be associated with Dr. Braswell Collins at 740 Hemlock St.; and Dr. Ham Hightower, neurosurgeon, who will be associated with Dr. Robert Clark and Dr. Hugh Smisson at 740 Hemlock St.

They were received into the society at its monthly meeting, June 1, 1965.

Cobb County doctors and ministers have entered a joint program of total care for patients at Kennestone Hospital, Marietta. The program grows out of the con-

cern for the necessity to utilize man's faith in God in the treatment of his illness.

The program was initiated by the COBB COUNTY MEDICAL SOCIETY in early 1964.

In late May approximately 40 clergymen and physicians met at Kennestone to participate in a program entitled "Guilt and Grace," led by the Rev. Joseph Walker and Dr. Talbert Williams.

Members of the Cobb County Committee of Medicine and Religion are, Dr. Noah Meadows, Dr. Luther Fortson, Rev. Walker, Dr. Charles Underwood, Dr. W. H. Benson, Dr. Al Miller, Dr. Harry Holland, Father Depriest and Dr. Williams.

## PERSONALS

The Georgia Society of Internal Medicine recently elected its 1965-1966 officers. JOSEPH WILSON, Atlanta, will serve as President; JOHN ELLIOTT of Savannah as President-Elect; and MAX M. BLUMBERG, Atlanta, as Secretary-Treasurer.

### Fourth District

BEN H. JENKINS, Newnan eye, ear, nose and throat specialist, was recently awarded first place in scientific exhibits at the convention of the Industrial Medical Association in Miami, Florida. Dr. Jenkins' exhibit was on "Ocular Emergencies."

### Fifth District

ROBERT E. HUIE, Decatur, has been advised by the Board of Directors of the American Academy of General Practice, that he has been appointed to the Committee on Medical Economics of the AAGP. This is one of the important committees of the Academy and an honor to Dr. Huie for his many years of active participation in the affairs of the Academy.

WILLIAM W. COPPEDGE took office as chief of the medical staff for South Fulton Hospital, East Point, July 1, 1965. CLAUD P. COBB, JR. was elected vice-chief of staff; ARTHUR J. CRUMBLEY, JR., Secretary; W. BEN DAVIS, chief of staff-elect and ALFRED JOSEPH, chief of pediatrics. Also taking office were GUY C. DAVIS, chief of surgery; DAVID G. STROUP, chief of obstetrics and gynecology; and LANIER JONES, chief of internal medicine.

BRUCE LOGUE, Atlanta, was recently guest lecturer at the New York University Medical School at the Postgraduate Course on Auscultation of the Heart sponsored by the American College of Surgeons.

Dr. and Mrs. THOMAS R. NOLAN of Atlanta were guests of the Fifth International Medical-Surgical Meeting in Turino, Italy, from June 5-13, 1965. Dr. Nolan was invited to join the symposium on "The Regional Treatment of Tumors With Chemotherapeutic Agents



and Radioisotopes." He presented a report of the results of treating over 70 advanced cancers by intra-arterial radioisotopes. The panel included papers from France, Italy and the United States and occupied two complete days of the program.

R. HUGH WOOD, Atlanta, Professor of Internal Medicine at Emory University School of Medicine will retire August 31, 1965, after completing 41 years of service with Emory University.

**Sixth District**

Former Atlanta physician, 81-year-old C. D. VINSON, believes that people should keep busy. To prove his point, Dr. Vinson is currently writing a book about his favorite hobby, toymaking. The book is entitled, "Every Boy's Favorite Book—Toymaking for Boys." Dr. Vinson is currently retired in Macon.

BRASWELL E. COLLINS and S. FLEETWOOD MADDOX, Macon, have recently announced their association in the practice of Ophthalmology. Dr. Mad-

dox will place emphasis on Pediatric Ophthalmology for which he has taken additional training.

**Eighth District**

Dr. and Mrs. D. C. STECKER attended the Annual Meeting of the American Medical Association held June 20-24 in New York City.

**Tenth District**

Four Augusta doctors, ROBERT B. GREENBLAT, J. ROGERS BYRD, VIRENDRA B. MAHESH and PAUL McDONOUGH, were awarded a silver medal from the American Medical Association for the second highest honor conferred in the association's scientific exhibits, which were shown at the Annual AMA Convention in New York City in June. The exhibit, "The Spectrum of Gonadal Dysgenesis," covered 20 square feet of floor space and included pictures, drawings and other related material. All four men are members of the Department of Endocrinology of the Medical College of Georgia, Augusta. The award was the highest ever won by the department, which sponsored the exhibit.

**COURSE IN ORTHOPTICS TO BE OFFERED  
BY EMORY UNIVERSITY SCHOOL OF MEDICINE**

The Department of Ophthalmology, Emory University School of Medicine, Atlanta, Georgia, offers a 15 month course in orthoptic training fulfilling the requirements of the syllabus of the American Orthoptic Council. Lectures are given in Anatomy, Physiology, Optics, Orthoptics and Applied Ophthalmology. Practical experience is obtained in the orthoptic clinics of Emory University and Grady Memorial Hospital. The

course commences in August, 1965. Applicants who are registered nurses or who have a bachelor's degree will be considered.

Inquiries and applications should be addressed to Charles F. Cooper, Jr., M.D., Chief of Motility Section, or Miss Betty Anne Jones, Chief Orthoptist, Emory Orthoptic Training School, Emory University Clinic, Atlanta 22, Georgia.

**1965 CALENDAR OF MEETINGS**

**State**

- September 20-21—Seventeenth Annual Scientific Session of the Georgia Heart Association, Biltmore Hotel, Atlanta.
- September 23—The Greater Atlanta Cancer Symposium, sponsored by the Cobb County Medical Society, the Cobb County Dental Society and the American Cancer Society, Georgia Division; Auditorium on the Mall, Cobb County Center, Marietta.
- September 27-October 1—Five Days of Internal Medicine, sponsored by the Department of Medicine, Emory University School of Medicine, Grady Memorial Hospital, Atlanta.
- May 8-10, 1966—112th Annual Session of the Medical Association of Georgia, Columbus.

**Regional**

- September 9-11—American Association of Obstetricians and Gynecologists, Homestead, Hot Springs, Va.
- September 14-17—American Association of Blood Banks, Americana Hotel, Bal Harbour, Fla.
- September 20-24—American College of Physicians presents Postgraduate Course No. 1, "Basic Mechanisms in

Internal Medicine," Medical College of Virginia, Richmond, Va.

- September 27-28—Tennessee Valley Medical Assembly, Tivoli Theatre, Chattanooga, Tenn.
- October 14-16—Pediatric Postgraduate Seminar, College of Medicine, University of Florida, Gainesville, Fla.
- November 1-4—Fifty-Ninth Annual Meeting of the Southern Medical Association, Houston, Texas.
- November 1-4—Annual Meeting of the Section on Otolaryngology of the Southern Medical Association, Houston, Texas.

**National**

- September 15, 1965-June 15, 1966—A nine month tutorial program in Cardiology offered by the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.
- November 15-18—Interstate Postgraduate Association of North America, Cleveland Assembly, Cleveland, Ohio.
- November 19-22—1965 Annual Meeting of the National Society for Crippled Children and Adults (The Easter Seal Society), Palmer House, Chicago.
- November 28-December 1—American Medical Association (Clinical Convention), Philadelphia.



## SUMMARY OF RECENT MAG COUNCIL AND EXECUTIVE COMMITTEE ACTIONS

(The full minutes from which these summaries have been abstracted are available to any MAG member upon request to the Journal.)

### Executive Committee / May 1, 1965

**Appointment to Rural Health Subcommittee**—The Executive Committee voted to appoint Irving D. Hellenga, Toccoa, and H. G. Davis, Jr., Sylvester, to the Rural Health Subcommittee. These appointments had been requested by Thomas N. Lumsden, Chairman of this committee.

**Radiation Control Council Advisory Committee Appointments**—Appointments to the Advisory Committee for the Radiation Control Council were considered and the following were made: (1) Edgar Grady, Atlanta; (2) Robert Lee Oliver, Savannah; (3) Herbert M. Olnick, Macon; (4) Richard A. Elmer, Atlanta; and (5) Stephen W. Brown, Augusta.

**Treasurer's Report**—Dr. Atwater gave the Treasurer's report which, on motion (Dillinger-Simpson), was approved and referred to Council.

**Resolution to Commend AMA on H.R. 6675 Campaign**—Dr. Mauldin read the following resolution:

"WHEREAS, on April 8, 1965, the House of Representatives of the Congress adopted the Administration supported Social Security financed health care for the aged plan (H.R. 6675) over the strong, persistent, and intelligently articulated opposition of the American Medical Association, the Medical Association of Georgia and other State and county medical societies and individual physicians throughout the country, and

"WHEREAS, The determined leadership given by the AMA in this legislative campaign accurately and correctly mirrors the true feelings of the vast majority of practicing physicians in Georgia and across the nation, and eloquently testifies to the fact that the AMA is responsive to the wishes of its members,

"NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia does hereby go on record commending the Officers, Board of Trustees and staff of the American Medical Association for their conduct of this campaign, and

"BE IT FURTHER RESOLVED, that the Delegates from MAG to the American Medical Association be requested to introduce a similar resolution commending and expressing confidence in the AMA at the June, 1965 meeting of the AMA House of Delegates."

After discussion on motion duly made and seconded it was voted to refer this resolution to Council with the recommendation for approval.

**Headquarters Office Report**—Mr. Krueger reported that the Headquarters office staff is at full capacity now and is functioning well.

**Old Business**—Mr. Krueger reported that there were a few members in certain county societies who had not paid dues and according to the MAG Constitution and Bylaws these members could not vote. The Executive Committee agreed that the Constitution and Bylaws should be followed but that if a member should pay his dues to his county society secretary or another officer of his county society, at the Annual Session and such dues received by MAG he could be registered to vote. It was recommended that Council be informed of this action and that a cut-off date should be established next year in order to avoid a repetition.

### Council / May 1, 1965

**Reading of Minutes**—Mr. Krueger reviewed the minutes of the Executive Committee and Council meetings of March 27-28, 1965. On motion these minutes were approved as read.

Mr. Krueger stated that there had been some discussion about the contribution to the retirement fund in that the bank and the MAG attorney questioned whether the funds were being contributed for 1964 or 1965. The plan states that the contribution shall be made by December 31 of each year. As the audit is not completed until March of each year, it had been suggested that the plan be amended effective and dated December 31, 1964, to provide that the employer's contribution be paid to the trustee not later than 90 days after the close of the calendar year and that the contribution in question should be allocated to the participants as though contributed December 31, 1964. On motion (Bohler-Andrews) it was voted to ask the MAG attorney to

rewrite the present retirement plan to conform to the above, and submit it to Council for approval in June.

**Additional MAG Certificates of Appreciation**—Dr. Mauldin recommended that J. Frank Walker be given a Certificate of Appreciation for his activities in legislation. On motion (Mauldin-Dillinger) Council approved this recommendation.

**Report of Constitution and Bylaws Board**—Dr. Mauldin reported that the Constitution and Bylaws Board had approved the resolution, which had been referred by Council and which would allow the Immediate Past President to serve on Council for three years, the first year of which he serves on the Executive Committee, and an additional two years as an ex-officio member of Council. Council then voted to refer this recommendation to the House of Delegates as a Supplemental Report of Council.

### NEW BUSINESS—

**Co-sponsorship of Continuing Education Courses**—Dr. Goodwin discussed the request of the Continuing Education Department of the Medical College of Georgia for MAG co-sponsorship of the courses outlined. On motion (Alexander-Dillinger) Council so voted to comply with this request.

**Resolution of Sympathy**—Dr. Ellington made the motion that Council submit a Resolution of Sympathy in the Death of Governor Carl Sander's Father to the House of Delegates as a Supplemental Report of Council. Council so approved and the resolution reads as follows:

#### "Resolution of Sympathy—In Memoriam"

"WHEREAS, Almighty God, in His Infinite Wisdom, has seen fit to take suddenly from our midst, Mister Carl Thomas Sanders, father of the Honorable Carl E. Sanders, Governor of the State of Georgia, and

"WHEREAS, the members of the Medical Association of Georgia wish to express their deep sympathy, and

"BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia in executive session adopts this minute acknowledging this loss, and

"BE IT FURTHER RESOLVED, that a copy of this resolution of sympathy be permanently placed in the minutes of this meeting, and that a copy be sent to Governor Carl E. Sanders with our condolence.

Dated this May 1, 1965, at Augusta, Georgia."

### 1965-66 Organization Meeting of Council / May 4, 1965

The attendance at the Council meetings May 1 and 4 is recorded in the minutes of the May 1 meeting with the addition of: Lamar B. Peacock, Atlanta; Harrison L. Rogers, Jr., Atlanta; M. F. Simmons, Decatur; Fleming L. Jolly, Atlanta; J. Harold Harrison, Atlanta; and T. A. Sappington, Thomaston. The staff was represented by Mr. Milton Krueger and Mrs. Catherine Wooten.

**Welcome to New Councilors**—Dr. Alexander welcomed the new members of Council as listed above.

**Nomination and Election of Council Chairman and Vice Chairman for 1965-66**—On motion (Bohler-Pinson) Charles R. Andrews, Jr., Canton, was elected Chairman of Council for 1965-66. On further motion (Sanders-Simpson) Frank Wilson, Leslie, was elected Vice Chairman of Council for 1965-66.

Dr. Andrews then took the gavel to assume his duties as Chairman of Council and proceeded with the business at hand.

**Council Appointment of Editor**—On motion duly made and seconded Council voted to reappoint Edgar Woody, Jr., Atlanta, as Editor of JMAG.

**Appointment of Council Finance Committee by Council Chairman**—With agreement of Council, F. G. Eldridge, Valdosta, was appointed Chairman of the Finance Committee, with Charles E. Bohler, Brooklet, and W. Frank McKemie, Albany, as members. The Treasurer, John S. Atwater, Atlanta, is an ex-officio member of the Finance Committee.

### 1965-66 Organization Meeting of Executive Committee / May 4, 1965

**Appointment of Treasurer for 1965-66**—On motion (Mauldin-McDaniel) the Executive Committee voted to recommend that John S. Atwater, Atlanta, be reappointed Association Treasurer for 1965-66.



TO: ALL MEMBERS, MEDICAL ASSOCIATION OF GEORGIA  
 RE: ENACTMENT OF "MEDICARE" BILL (H.R. 6675)

ON JULY 30, 1965 PRESIDENT JOHNSON SIGNED INTO LAW THE "SOCIAL SECURITY AMENDMENTS OF 1965" NOW KNOWN AS PUBLIC LAW 89-97. THIS LAW, STRONGLY OPPOSED BY THE MEDICAL PROFESSION, IS ONE OF THE MOST COMPREHENSIVE AND COMPLEX PIECES OF LEGISLATION EVER ENACTED BY CONGRESS. THE LAW HAS FOUR (4) TITLES AS FOLLOWS:

**JOURNAL**  
**OF THE MEDICAL**  
**ASSOCIATION**

SEPTEMBER / 1965  
*Georgia*

TITLE I IS CONCERNED WITH HEALTH INSURANCE FOR THE AGED AND HAS TWO PARTS. PART 1 HAS THREE SUBPARTS, NAMELY: PART A ESTABLISHES A HOSPITAL INSURANCE PROGRAM PATTERNED AFTER THE KING-ANDERSON BILL; PART B ESTABLISHES A VOLUNTARY, FEDERALLY ADMINISTERED MEDICAL INSURANCE PROGRAM TO PROVIDE BENEFITS WHICH SUPPLEMENT THE BENEFITS UNDER THE KING-ANDERSON PROGRAM; AND PART C CONTAINS DEFINITIONS AND PROVISIONS RELATING TO THE ADMINISTRATION OF PARTS A AND B. PART 2 OF TITLE I ESTABLISHES A NEW PROGRAM WHICH WILL REPLACE THE EXISTING PROGRAMS FOR MEDICAL ASSISTANCE UNDER THE PUBLIC ASSISTANCE PROGRAMS.

TITLE II AMENDS THE MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S PROGRAMS, EXTENDS THE GRANT PROGRAM FOR MENTAL RETARDATION PLANNING, AMENDS THE PUBLIC ASSISTANCE PROGRAMS TO AUTHORIZE FEDERAL PARTICIPATION IN ASSISTANCE TO AGED INDIVIDUALS WITH TUBERCULOSIS OR MENTAL DISEASE, AND AUTHORIZES APPROPRIATIONS FOR A STUDY OF ALL RESOURCES FOR THE DIAGNOSIS AND PREVENTION OF EMOTIONAL ILLNESS IN CHILDREN.

TITLE III MAKES NUMEROUS AMENDMENTS TO THE OLD-AGE AND SURVIVORS INSURANCE AND DISABILITY INSURANCE PROGRAMS UNDER THE SOCIAL SECURITY ACT, INCLUDING COMPULSORY COVERAGE FOR PHYSICIANS, PAYMENTS FOR NON-PERMANENT DISABILITY, AND INCREASES IN THE TAXABLE WAGE BASE AND TAX RATE.

TITLE IV AMENDS THE PUBLIC ASSISTANCE PROGRAMS TO PROVIDE, AMONG OTHER THINGS, INCREASES IN THE FEDERAL CONTRIBUTIONS FOR THOSE PROGRAMS.

LEGISLATIVE ANALYSIS: "TITLE I - HEALTH INSURANCE FOR THE AGED AND MEDICAL ASSISTANCE"

PART 1-A -- HEALTH INSURANCE BENEFITS FOR THE AGED --

THIS TITLE AMENDS THE OLD-AGE AND SURVIVORS INSURANCE ACT, AND ADDS A NEW TITLE (XVIII) TO, THE SOCIAL SECURITY ACT, UNDER WHICH INPATIENT HOSPITAL SERVICES, POST-HOSPITAL EXTENDED CARE SERVICES, POST-HOSPITAL HOME HEALTH SERVICES, AND OUTPATIENT HOSPITAL DIAGNOSTIC WILL BE PROVIDED TO: (A) ANY INDIVIDUAL 65 YEARS OF AGE OR OVER WHO IS ENTITLED TO MONTHLY INSURANCE BENEFITS UNDER TITLE II OF THE SOCIAL SECURITY LAW, WHETHER OR NOT HE IS RECEIVING THEM; (B) ANY INDIVIDUAL 65 YEARS OF AGE WHO IS NOT ENTITLED TO BENEFITS UNDER THE SOCIAL SECURITY OR RAILROAD RETIREMENT LAWS, WHO ATTAINS THAT AGE BEFORE 1968; AND (C) AFTER 1968, ANYONE WHO HAS THREE QUARTERS OF COVERAGE, WHENEVER ACQUIRED, UNDER THE SOCIAL SECURITY OR RAILROAD RETIREMENT LAWS FOR EACH YEAR THAT ELAPSES AFTER 1965 AND BEFORE HE ATTAINS AGE 65.

BENEFITS: PAYMENT IS AUTHORIZED ON BEHALF OF AN ELIGIBLE INDIVIDUAL FOR THE FOLLOWING SERVICES SUBJECT TO DEDUCTIBLES DESCRIBED BELOW:

INPATIENT HOSPITAL SERVICES (INCLUDING SERVICES IN A PSYCHIATRIC OR TUBERCULOSIS HOSPITAL) FOR UP TO 90 DAYS IN SEMIPRIVATE ACCOMMODATIONS (TWO TO FOUR BED) DURING A SPELL OF ILLNESS.

POST-HOSPITAL EXTENDED CARE SERVICES FOR UP TO 100 DAYS DURING ANY SPELL OF ILLNESS IN A FACILITY WHICH HAS IN EFFECT A TRANSFER AGREEMENT WITH ONE OR MORE HOSPITALS OR WHICH A STATE AGENCY FINDS HAS ATTEMPTED TO ENTER INTO SUCH AN AGREEMENT.

**NEW MEDICARE LAW**  
**SEE PAGES 307 & 314**





an important contribution to the practice of medicine

# CHLOROMYCETIN<sup>®</sup>

(CHLORAMPHENICOL)

PARKE-DAVIS

PARKE-DAVIS COMPANY, Detroit, Michigan 48232

Complete information for usage available to physicians upon request.

73883



JOURNAL  
OF THE MEDICAL  
ASSOCIATION

Georgía

Contents

EDITOR

Edgar Woody, Jr., M.D.

MANAGING EDITOR

Miss Merrillie M. Davis

STAFF

Thelma V. Franklin, *Business*

CONTRIBUTING EDITORS

Herbert S. Alden, M.D.; Preston D. Ellington, M.D.; Thomas Findley, M.D.; J. Willis Hurst, M.D.; Charles S. Jones, M.D.; Arthur M. Knight, Jr., M.D.; Arthur J. Merrill, M.D.; Lester Rumble, Jr., M.D.; Peter L. Scardino, M.D.; Patrick C. Shea, Jr., M.D.; Robert H. Vaughan, M.D.

PUBLICATIONS COMMITTEE

George H. Alexander, M.D.; Walter E. Brown, M.D.; J. G. McDaniel, M.D.; Henry S. Jennings, M.D.; Charles R. Andrews, Jr., M.D.; John T. Mauldin, M.D.; John S. Atwater, M.D.; F. G. Eldridge, M.D.

THE ASSOCIATION

George H. Alexander, M.D., *Pres.*; Walter E. Brown, M.D., *Pres.-Elect*; J. G. McDaniel, M.D., *Past Pres.*; Charles R. Andrews, Jr., M.D., *Chm. of Council*; John T. Mauldin, M.D., *Sec.*; John S. Atwater, M.D., *Treas.*; J. Frank Walker, M.D., *Speaker*; Mr. Milton D. Krueger, *Exec. Sec.*; Mr. James M. Moffett, *Asst. Exec. Sec.*; Mrs. Catherine Wooten, *Asst. Exec. Sec.*

THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and copyrighted, 1965, by the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309. Published monthly under the direction of the Council of the Association. Subscription rate: \$7 per year; \$1 per single copy. Second-class postage paid at Fulton, Missouri.

CHANGING CONCEPTS OF CARDIOVASCULAR DISEASE IN CHILDREN Gordon M. Folger, M.D.	291
AN EVALUATION OF SURGERY FOR HIATAL HERNIA AND PEPTIC ESOPHAGITIS E. R. Woodward, M.D.; H. Schapiro, Ph.D., and M. Michael Eisenberg, M.D.	297
A STUDY OF THE EFFECT OF PHENERGAN AND VISTARIL IN COMBINATION WITH DEMEROL ON LABOR AND DELIVERY Hoyt C. Dees, M.D.	301
RECURRENT APPENDICITIS AFTER "APPENDECTOMY" James R. Shamblin, M.D. and Thomas L. Hudson, Major, MC	304

Editorials

THE NEW MEDICARE LAW	307
REGIONAL MEDICAL COMPLEXES The President's War on Heart Disease, Cancer and Stroke	308
THE PHYSICIAN'S RESPONSIBILITY IN MENTAL HEALTH PROGRAMS	309
"IT TAKES A SMART DOCTOR TO STAY OUT OF GOD'S WAY"	309

Features

President's Letter	311
Heart Page	313
Legal Page	314
Mental Health Page	316
Abstracts	317

The Association

Deaths	318
Societies	318
Personals	318
Advertising Index	56A
Calendar	310

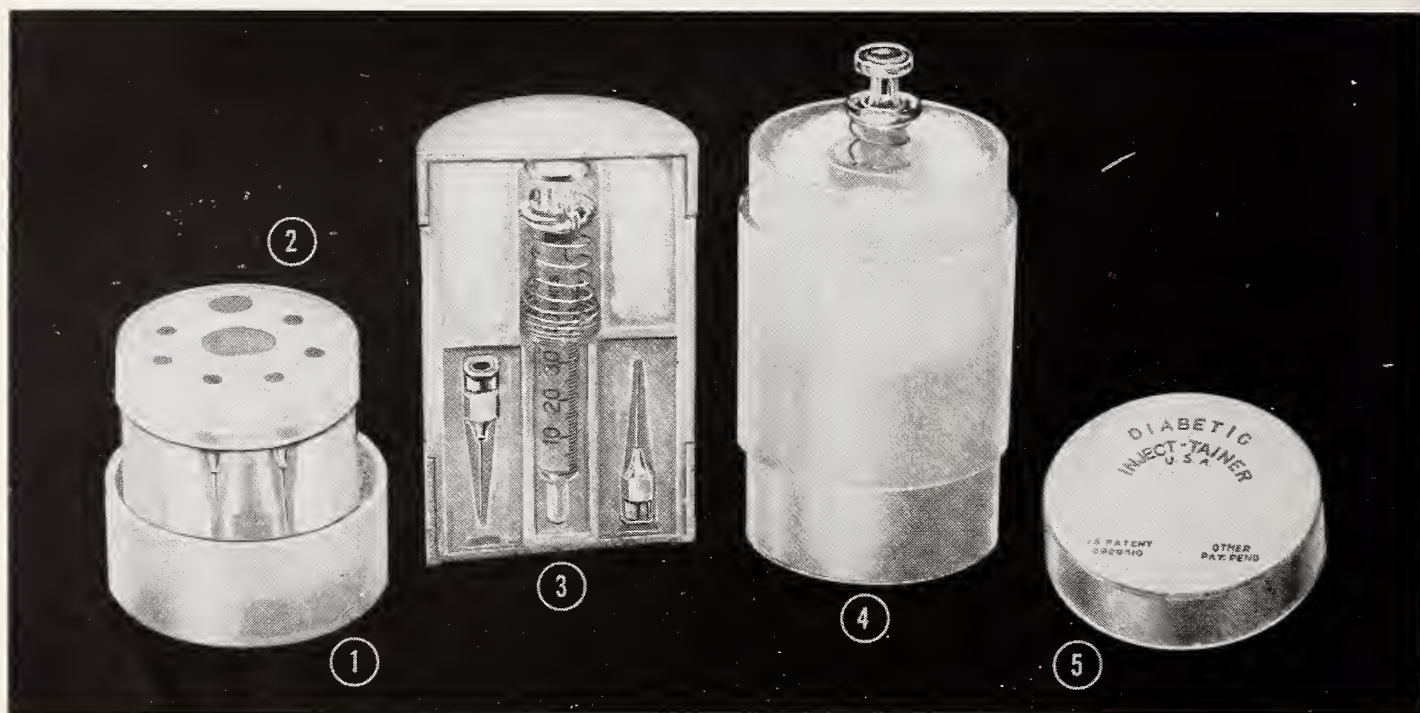
Cover

Design by Noel Smith, Atlanta.

# Help your Diabetic Patients!

Recommend the  
Diabetic Inject-Tainer

*New Carrying Convenience Holds Six (6)  
Needles & Syringe. Stops Barb Pointed Needles*



## A Diabetic's Dream for Convenience

Complete with six (6) 26-gauge  $\frac{1}{2}$ -inch needles, glass tip 40/80 unit short insulin syringe and carrying case. Only \$6.00.

Remove top cover to expose "pop-up" syringe and cotton. Turn cover #2 over needle—press syringe into needle and twist. Return used needle to opposite end of Inject-Tainer (used and sterilized needles are totally separated).

When six (6) needles need sterilization, simply drop Inject-Tainer into boiling water.



Two fingers only!!  
Alcohol Dispenser  
No Dipping—  
No Dripping  
Screw dispenser  
onto alcohol bottle—  
place cotton on  
top and press.  
Price \$1.00,  
Free with  
Inject-Tainer

Order from:

**WIL-PEN COMPANY**

P. O. Box 1036  
Decatur, Ga.



# CHANGING CONCEPTS OF CARDIOVASCULAR DISEASE IN CHILDREN

Gordon M. Folger, Jr., M.D., *Augusta*

■ A vastly improved prognosis is now  
seen with these defects.

**T**HE THIRTY YEARS since Maude Abbott compiled and published her experience with congenital cardiovascular malformations<sup>1</sup> have seen a remarkable change in this field. The hopelessness which accompanied the child with a congenital cardiovascular defect has given way to a new outlook for these individuals which commenced with Gross<sup>2</sup> description of the treatment of patent ductus arteriosus in 1939 and received great impetus in 1945 when Blalock and Taussig<sup>3</sup> described the systemic to pulmonary artery shunt for patients with defects associated with pulmonic stenosis.

## Current Concepts

With the continuation of dramatic advances in diagnostic techniques and surgical procedures, all but the most complicated defects are now amenable to either palliative or corrective surgical procedures or both. It is the purpose of this communication to review the spectrum of congenital heart disease from the diagnostic and corrective aspects and to present some of the current concepts of this important field.

### *Diagnostic studies:*

With the advances in surgical techniques and procedures has come the ever increasing need for refinements in diagnostic methods. Although complete assessment of the clinical findings will lead to the correct diagnosis in the majority of instances, the surgeon needs to be aware of the exact location of defects, the presence of coexisting defects which might complicate the procedure and the hemodynamic situations obtainable only by more refined techniques. Chief among these is the cardiac catheterization employing the routine analysis of oxygen saturations for the detection of shunts, the recording of pressure

data, and accompanying studies such as indicator-dilution techniques and angiocardiology. In this laboratory cineangiocardiology employing the photography of the fluoroscopic image tube on 16 mm. motion picture film, during the injection of contrast material, is used as a standard procedure. Figures 1-4 illustrate the anatomic appearances of several defects diagnosed by this technic. Exact diagnosis by such means can be made in nearly all patients.

Radioisotope scanning<sup>4-5</sup> of the heart and viscera is a valuable aid to diagnosis in some patients (Figure 5). Myocardial biopsy<sup>6</sup> is being performed satisfactorily by some groups and has great promise for the future in the diagnosis of primary endomyocardial disease.

FIGURES 1-4

AO = aorta  
PA = pulmonary artery  
LV = left ventricle  
RV = right ventricle  
VSD = ventricular septal defect

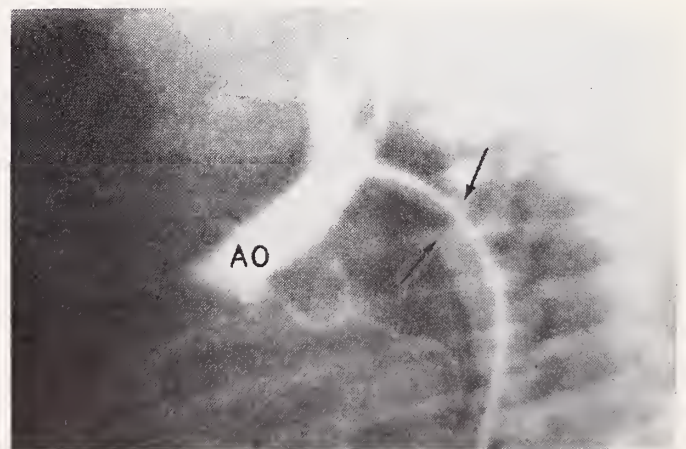


FIGURE 1

A case of transposition of the great vessels and coarctation of the aorta. Left anterior oblique projection. Injection in aorta. Note that the aorta arises anteriorly with its valve higher than usual. The isthmus is hypoplastic and beyond this segment is the coarcted area (arrows) followed by a normal aortic lumen size. Of further interest is the single origin of the coronary arteries.

*From the Department of Pediatrics and the Hemodynamic Research Unit, Medical College of Georgia.*

*Supported in part by U.S.P.H. Service Grant No. HE07266.*



## *Surgical procedures:*

The present report is not intended as a treatise on surgical cardiovascular procedures. In general, surgery has two areas in which to treat the patient with a cardiovascular defect: palliation or complete correction. The palliative procedures are numerous. Chief among them are the various forms of systemic artery to pulmonary artery<sup>3, 7</sup> or superior vena cava to pulmonary artery<sup>8</sup> anastomosis for patients suffering from reduced pulmonary blood flow, banding of the pulmonary artery<sup>9</sup> in patients with extreme left to right shunts and creation of atrial septal defects<sup>10</sup> for transposition of the great vessels.

The corrective procedures may be divided into those which employ cardiopulmonary bypass and those in which this is not required.

Even though surgical procedures may be available for the treatment of a specific defect of the heart or great vessels, there are certain reservations to their use and its timing which will become more evident in the remainder of this discussion.

## *Specific defects:*

Table I illustrates the division of the more commonly encountered abnormalities on the basis of the availability of surgical treatment. In many instances both palliative and corrective procedures are available, the use of either depending on a number of variables, whereas some are amenable at present only to palliation.

*Group I A.* Acyanotic defects comprise about 70% of all congenital heart lesions. The most common and readily treatable will be mentioned.

*Ventricular septal defect:* Recent studies by a number of investigators indicating a significant spontaneous closure rate in patients with VSD, in addition

to evolving ideas about the hazard of the development of pulmonary hypertension in these patients,<sup>11, 12</sup> has led to an approach to the treatment of this defect which is considerably more conservative than was formerly proposed. This is especially true for the small to moderate sized defects with few or no symptoms. Even in these patients, however, one cannot completely disregard the risk, though small, of such complications as bacterial endocarditis or the development of aortic insufficiency and weigh them against the risk of surgical correction.

The infant or small child in difficulty with this defect, however, represents a significantly different problem. In these patients, medical management is often less satisfactory and surgery may be lifesaving. Because of the technical problems associated with total correction of these defects in the infancy period, the placing of a constricting band on the main pulmonary artery (pulmonary banding)<sup>9</sup> is widely employed as a palliative measure. In this manner both the blood flow and pressure to the pulmonary vascular bed is reduced and corrective procedures may be undertaken at a more suitable age and size.

*Patent ductus arteriosus:* Thinking concerning the management of this defect has not changed appreciably since the advent of a method of surgical correction. In general, the lesion is seen as a cause of cardiac decompensation, often of a severe degree in the infant or as an incidental finding on routine examination in the older child or adult having caused few or no symptoms. The former problem requires immediate medical management and surgical intervention. Ligation of the asymptomatic ductus is recommended as an elective procedure, preferably after the age of three to five years. The complications of pulmonary hypertension and bacterial endocarditis though infrequent are real and bear consideration in any child with patency of the ductus arteriosus.

In the infant with congestive heart failure the presence of a patent ductus associated with another defect such as ventricular septal defect or coarctation of the aorta must always be considered. In such instances the typical ductus murmur is often not heard and the diagnosis rests entirely with physiologic studies and angiocardiology. Closure of the ductus alone in such instances may often be sufficient to cause alleviation of the acute symptoms.

## *Atrial septal defect:*

1. *Ostium secundum.* Easily diagnosed, both clinically and by hemodynamic techniques, this defect is frequently well tolerated by the patient, who in spite of a sizeable left to right shunt may have only mild symptoms. Complications are rare. Because of this, surgery is almost always elective. It is now con-

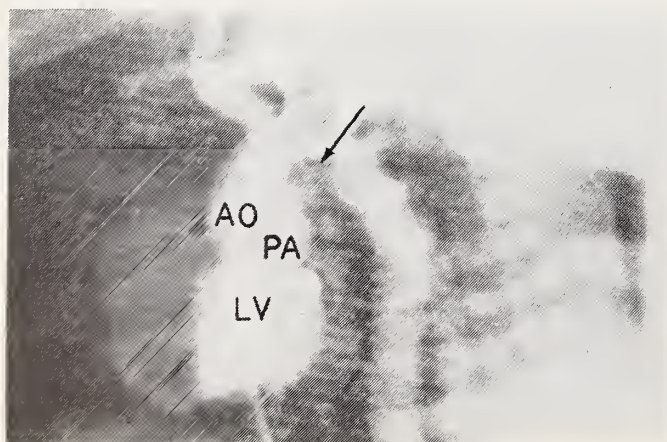


FIGURE 2

Patent ductus arteriosus. Injection has been made into the left ventricle in the left anterior oblique projection. The ventricular septum is intact and no opacification of the anteriorly placed right ventricle has taken place. However, the aorta and pulmonary artery are equally well opacified and the ductus arteriosus is readily visualized (arrow).



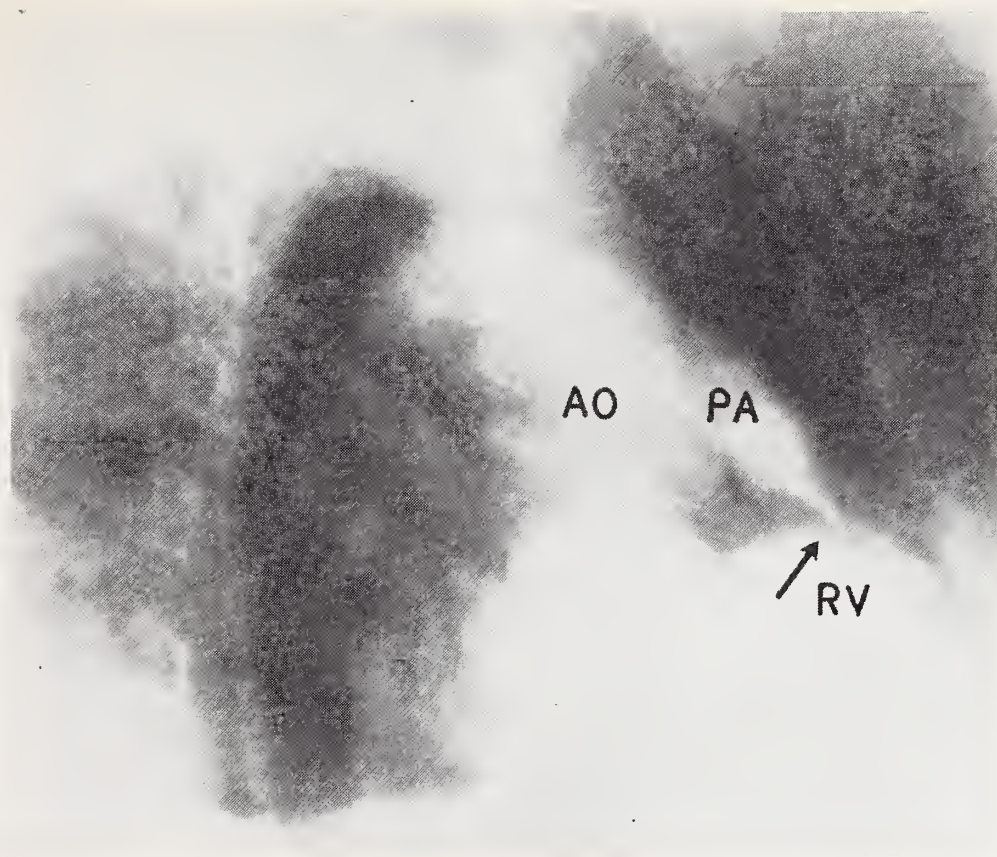


FIGURE 3

Tetralogy of Fallot. Right anterior oblique projection, injection into right ventricle. Of note in this view is the marked narrowing of the right ventricular outflow area (arrow) above which is the infundibular chamber of the right ventricle. Beyond this chamber is the pulmonary artery. The discrepancy in size between the pulmonary artery and the simultaneously opacified aorta is apparent.

TABLE I  
CLASSIFICATION OF CARDIOVASCULAR MALFORMATIONS ON THE BASIS OF  
AVAILABILITY OF SURGICAL TREATMENT.

Group	Hemodynamic Type	Malformations	Surgical Procedure
I Surgical Procedure Available	A Acyanotic	Ventricular Septal Defect Patent Ductus Arteriosus Atrial Septal Defect Valvular pulmonary stenosis Coarctation of Aorta Aortic Stenosis	C* and P** C C C C C
	B Cyanotic	Tetralogy of Fallot Transposition of Great Vessels Tricuspid Atresia Anomalies of pulmonary venous connection	C and P C and P P C
II Surgical Procedure	A Acyanotic	Cardiomyopathy Primary pulmonary Hypertension Certain hypoplasias involving the left heart	
Currently Not Available	B Cyanotic	Generally complicated defects involving absence of cardiovascular components I.E. single ventricle, left heart valvular atresia or severe hypoplasia	

\*C—Corrective Surgical Procedure.  
\*\*P—Palliative Surgical Procedure.

sidered wisest to perform surgical correction employing cardiopulmonary bypass rather than hypothermic procedures in view of such complicating features as position and variations in size of the defect and the presence of anomalous pulmonary veins.

2. *Ostium primum*. The ostium primum defects of the atrial septum are always of the endocardial cushion type and their size and location in addition to the high incidence of associated A-V valve abnormalities places them in a somewhat different category both medically and surgically. Exact diagnosis both of the defect itself and of the presence of the usual complicating abnormalities is of utmost importance.

*Valvular pulmonary stenosis*: The problem of management of this relatively common lesion appears to be similar to that of ventricular septal defect. Indeed, much like the latter lesion, the criteria for pulmonary valvulotomy have also evolved as the natural course of the various degrees of severity of obstruction have been better understood. The diagnosis is usually entertained clinically and generally easily confirmed by cardiac catheterization and angiography.

The child with extreme stenosis of the pulmonary valve is often both a medical and surgical emergency requiring rapid and active support followed by surgi-

cal relief of the obstruction, whereas the moderate and mild degrees are usually relieved of obstruction electively when the patient attains a suitable size and age or often not at all. Complicating the entity is the occasional development of subacute bacterial endocarditis and variable degrees of subpulmonic stenosis which also may require correction.

Where feasible, correction of the defect employing cardiopulmonary bypass and so repairing the valve under direct vision is now the procedure of choice. By this method a more anatomic repair can often be achieved than is possible if closed valvotomy is utilized and the number of patients having residual difficulty postoperatively is reduced. In the severely ill infant, however, a transventricular valvulotomy may prove lifesaving and is still the procedure of choice in this age group.

*Coarctation of the aorta*: This abnormality also may cause severe illness in the infant and small child requiring immediate medical management and prompt surgical relief of the obstruction. In the asymptomatic child, current opinion favors repair when the child has achieved a size in which further increase in the aortic lumen is minimal, generally after the age of 13 years.

*Group I B—Cyanotic defects:*

*Tetralogy of Fallot*: With the description of a method of increasing pulmonary blood flow in the tetralogy of Fallot by subclavian artery to pulmonary

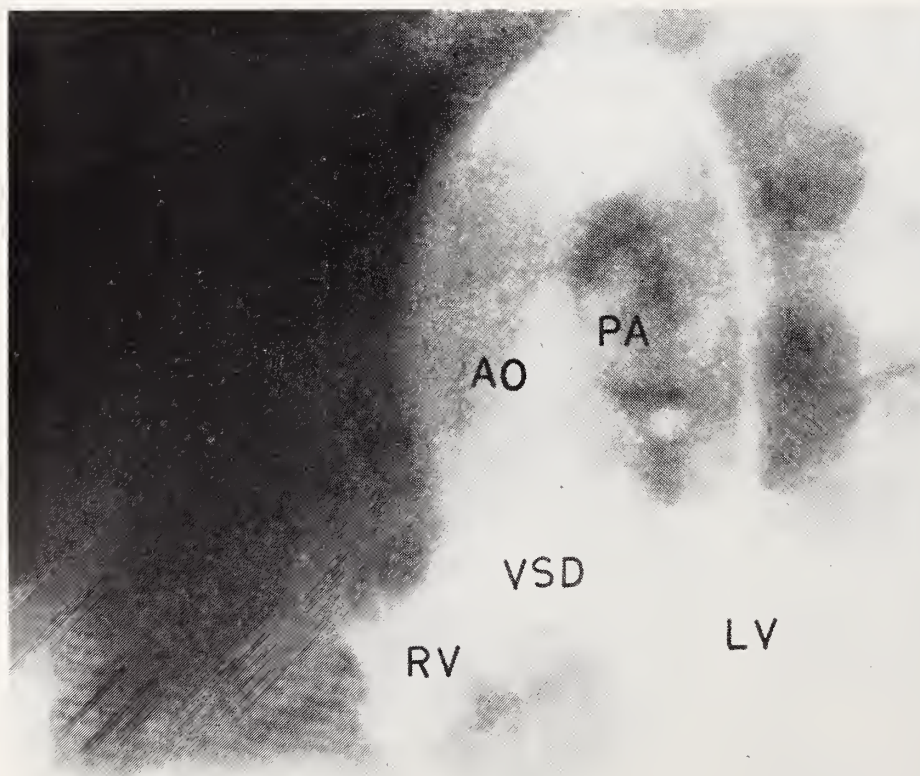


FIGURE 4

Tetralogy of Fallot. Left anterior oblique view. Here the projection is in the plane of the ventricular septum. The ventricular septal defect is readily apparent as is the large "over-riding" aorta.



artery anastomosis by Blalock and Taussig,<sup>3</sup> there commenced a revolution of renewed interest in the field of congenital heart defects. By the time open heart surgery was developed<sup>13</sup> it was apparent that this procedure and those described by Potts,<sup>7</sup> Brock,<sup>14</sup> and Glenn<sup>8</sup> had contributed greatly to the salvage of patients with this defect who could in the future be totally corrected. As further modifications of the open heart techniques allowed this type of surgery in small children, many physicians abandoned, to varying degrees, the anastomotic palliative procedures. However, the very small child in difficulty with tetralogy of Fallot is still best treated by palliation initially, with total correction at such time as his condition shows deterioration and when he is of such size that prosthetic devices when needed will not soon be outgrown resulting in the need for additional surgery. In this respect much is to be said for the use of anastomotic procedures even in older children rather than initial open heart correction. Such procedures serve to increase flow to a constricted pulmonary vascular bed and also to increase flow to the left side of the heart without calling on the surgically damaged right ventricle to institute this circulatory change.

### Acyanotic Tetralogy of Fallot

Comment should be made on the use of the term "acyanotic tetralogy of Fallot." That such a defect truly exists<sup>15</sup> is not questioned. However, the term tends to be given erroneously to patients with ventricular septal defects and pulmonary stenosis who both anatomically and physiologically do not and will never have a true tetralogy of Fallot. These patients behave differently clinically and are usually markedly different from a surgical aspect.

The diagnosis of tetralogy of Fallot is usually easily made from clinical and hemodynamic studies. Only the occasional transposition, single ventricle or double outlet right ventricle having pulmonary stenosis may be misleading enough to be confused with a tetralogy. The differentiation in such cases may not be made until the time of hemodynamic study.

*Transposition of the great vessels:* It is difficult to adequately describe the entity of transposition of the great vessels under one general heading so variable is its anatomy. However, so important are its variables to the course of the patient both in respect to medical management and surgical care, that they must be painstakingly delineated.

Not a rare defect, it occurs in approximately 8% of congenital cardiovascular anomalies according to Keith et al.<sup>16</sup> ranking comparably with atrial septal defect, pulmonic stenosis and coarctation of the aorta. It is one of the most common causes of cyanosis and congestive heart failure in newborns.

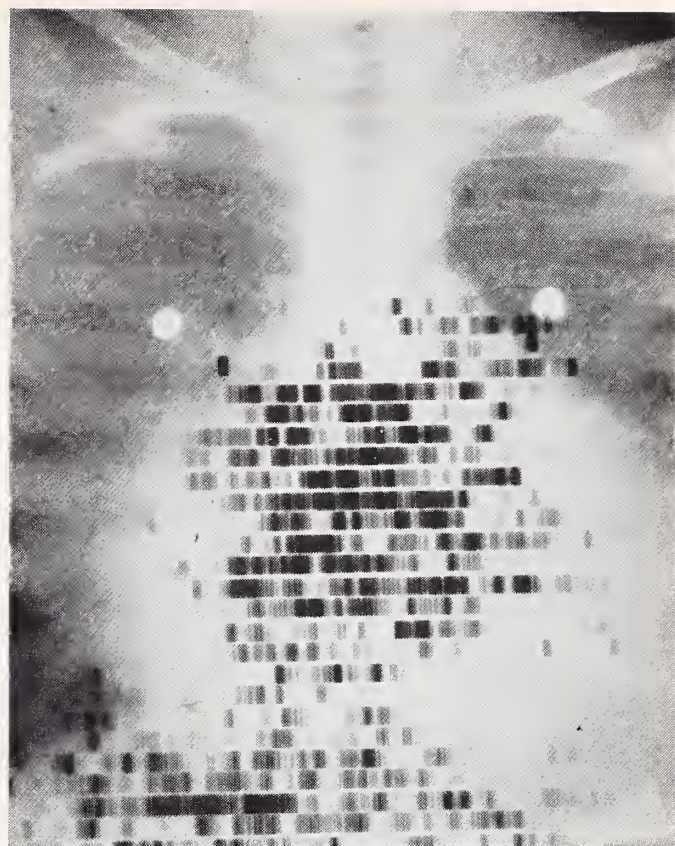


FIGURE 5

Radioisotope scan of a patient with pericardial effusion. The dark bars indicate activity of the radioactive <sup>1131</sup> contained in the intracavitary blood pool. The discrepancy between the blood pool and the lateral heart border is due to a large effusion. Some activity can also be seen in the hepatic blood pool.

The condition of the patient with transposition depends primarily on the size and effectiveness of the associated intra- or extracardiac shunts, and the absence or presence and degree of pulmonic stenosis. As a general rule the better the intracardiac mixing, the better the overall condition of the patient. The presence of minimal pulmonic stenosis serves to reduce both flow and the pressure transmitted to the pulmonary vascular bed, also favorably influencing the condition of the patient.

At present, palliative surgery aimed at improving admixture of the systemic and pulmonary venous blood by the creation of an atrial septal defect is the preferred method of treatment.<sup>10</sup> To this procedure it may be necessary to add pulmonary banding to reduce pressure and flow to the lungs in the absence of sufficient pulmonary stenosis or a systemic to pulmonary anastomosis if a severe degree of pulmonic stenosis is present.

Corrective surgical procedures are becoming available<sup>17, 18</sup> for this defect although widespread acceptance of present techniques has as yet not taken place. It is apparent that the outlook for these patients is changing significantly.

*Tricuspid atresia:* The clinical diagnosis of this defect is always suspected in a cyanotic patient exhibiting left axis deviation and left ventricular hyper-



trophy although other malformations as single ventricle or underdevelopment of the right ventricle may exhibit such findings. In cases of doubt cardiac catheterization and angiography will usually ascertain the diagnosis. The treatment at present is medical with surgical palliative measures utilizing systemic to pulmonary arterial shunts available if pulmonic stenosis is also present.

The list of defects both acyanotic and cyanotic which are currently amenable, with some reservations, to corrective surgery or which respond to palliative procedures could be extended. Though nonetheless important, they are uncommon and fall outside the scope of this report.

#### Group II:

A number of defects are of such type, due usually to anatomic atresias or to morphologic and physiologic complexity, to preclude definitive therapy. Furthermore, medical management almost invariably fails after variable periods of time and our present outlook for this group is indeed gloomy. Into this group fall certain types of atrial and ventricular septal absence, mitral and aortic atresia, severe interruptions of the aortic arch and varieties of the cardiomyopathies. It is in these types of defects that the picture of total cardiac replacement holds some promise.

#### Summary

The advances in diagnosis and management of children with cardiovascular anomalies have afforded a much brighter outlook to a large proportion of these children. As knowledge progresses even further in this field, it will contribute more toward our ability to better manage not only these children but to the treatment of those malformations not yet amenable to therapy. Because of this, it is important that the physician dealing with such patients recognize the vastly improved prognosis both as he treats the infant or child and as he counsels the parents.

Department of Pediatrics  
Medical College of Georgia

1. Abbott, M. E.: *Atlas of Congenital Cardiac Disease*. New York, The American Heart Association, 1936.
2. Gross, R. E. and Hubbard, J. P.: Surgical Ligation of a Patent Ductus Arteriosus; Report of First Successful Case. *J.A.M.A.* 112:729, 1939.
3. Blalock, A. and Taussig, H. B.: The Surgical Treatment of Malformations of the Heart in Which There Is Pulmonary Stenosis or Atresia. *J.A.M.A.* 128:189, 1945.
4. Wagner, H. N.: An Outline of the Use of Radioisotope Techniques in Medical Diagnosis. *Am. J. Med. Sciences* 247:601, 1964.
5. Shah, K. D.; Neill, C. A.; Wagner, H. N., Jr., and Taussig, H. B.: Radioisotope Scanning of the Liver and Spleen in Dextrocardia and In Situs Inversus with Levocardia. *Circulation* 29:231, 1964.
6. Konno, S. and Sakakibara, S.: Intracardiac Biopsy. Abstract. Supplement III. *Circulation* 30:108, 1964.
7. Potts, W. J.; Smith, S., and Gibson, S.: Anastomosis of the Aorta to a Pulmonary Artery. *J.A.M.A.* 132:627, 1946.
8. Glenn, W. W. L.: Circulatory Bypass of the Right Side of the Heart. IV. Shunt Between Superior Vena Cava and Distal Right Pulmonary Artery—Report of Clinical Application. *New England J. Med.* 259:117, 1958.
9. Muller, W. H., Jr. and Dammann, J. F., Jr.: The Treatment of Certain Congenital Malformations of the Heart by the Creation of Pulmonic Stenosis to Reduce Pulmonary Hypertension and Excessive Pulmonary Blood Flow. *Surg., Gynec., and Obst.* 95:213, 1952.
10. Blalock, A. and Hanlon, C. R.: Surgical Treatment of Complete Transposition of Aorta and Pulmonary Artery. *Surg., Gynec., and Obst.* 90:1, 1950.
11. Walker, W. J.; Garcia-Gonzalez, E.; Hall, R. J.; Czarnecki, S. W.; Franklin, R. B.; Das, S. K., and Cheitlin, M. D.: Interventricular Septal Defect. Analysis of 415 Catheterized Cases, Ninety with Serial Hemodynamic Studies. *Circulation* 31:54, 1965.
12. Bloomfield, D. K.: The Natural History of Ventricular Septal Defect in Patients Surviving Infancy. *Circulation* 29:914, 1964.
13. Lillehei, C. W.; Cohen, M.; Warden, H. E.; Read, R. C.; Aust, S. B.; DeWall, R. A., and Warco, R. L.: Direct Vision Intracardiac Surgical Correction of the Tetralogy of Fallot, Pentalogy of Fallot, and Pulmonary Atresia Defects; Report of First 10 Cases. *Ann. Surg.* 142:418, 1955.
14. Brock, R. C.: Pulmonary Valvulotomy for the Relief of Congenital Pulmonary Stenosis; Report of 3 Cases. *Brit. M. J.* 1:1121, 1948.
15. Gasul, B. M.; Dillon, R. F.; Vrla, V., and Hait, G.: Ventricular Septal Defects, Their Natural Transformation into Those with Infundibular Stenosis or into the Cyanotic or Noncyanotic Type of Tetralogy of Fallot. *J.A.M.A.* 164:847, 1957.
16. Keith, J. D.; Rowe, R. D., and Vlad, P.: *Heart Disease in Infancy and Childhood*. New York, The Macmillan Company, 1958.
17. Senning, A.: Surgical Correction of Transposition of the Great Vessels. *Surgery* 45:966, 1959.
18. Mustard, W. T.: Successful Two-Stage Correction of Transposition of the Great Vessels. *Surgery* 55:469, 1964.

## AMA AWARDS ADDITIONAL TOBACCO RESEARCH GRANTS

The American Medical Association Education and Research Foundation's Committee on Tobacco and Health has authorized the awarding of 15 new tobacco research grants.

The first-year grants for the new projects totaled more than \$474,000. Length of the research programs range from one to five years and full commitment for the duration will total in excess of \$1,280,000.

The Committee said these 15 additional grants bring to 43 the number of tobacco research projects AMA-ERF is currently giving financial support. The 43 programs have a total first-year commitment of approximately \$1,500,000 and a five-year potential expenditure of over \$3,600,000.

The grants are a part of a long-range research program on tobacco and health authorized in 1963 by the AMA House of Delegates.



# AN EVALUATION OF SURGERY FOR HIATAL HERNIA AND PEPTIC ESOPHAGITIS

E. R. Woodward, M.D.

H. Schapiro, Ph.D.

M. Michael Eisenberg, M.D.

Gainesville, Florida

- The use of vagotomy to reduce gastric secretion, and a drainage procedure to hasten gastric emptying appear to be beneficial.

THAT PEPTIC ESOPHAGITIS is a disease of increasing clinical importance may be inferred from the accumulating literature on the subject during the decade since Allison's classic report.<sup>1</sup> The manifestations of acid-peptic disease of the esophagus are in many respects similar to those in the stomach and duodenum and there is a growing volume of evidence supporting the thesis that some of the basic etiologic mechanisms are identical. The dictum of "no acid—no esophagitis" appears to hold equally well in these cases. The exquisite sensitivity of esophageal mucosa to the proteolytic effect of acid-pepsin is well known. This factor renders the physiologic separation of stomach from esophagus as crucial.

## Controversy Exists

Reflux of acid gastric juice from the stomach into the lower esophagus is prevented by a closure mechanism of the lower esophagus, although controversy still exists over its anatomic construction and *modus operandi*. Surgeons have regarded the hiatus as primary in importance, postulating that the thickened sling-shaped crural fibers act as the basic valve mechanism. In 1950, Lerche<sup>5</sup> presented a physioanatomic concept, subsequently modified by Gould and

Barnhard,<sup>3</sup> which indicates the existence of one esophageal sacculum and ampulla, one gastric or hiatal segmental vestibule, and an inferior esophageal sphincter made up of diffuse muscle in the wall of the ampulla.

Whatever the relative importance of the intrinsic and extrinsic factors, Code and associates have demonstrated a final common denominator.<sup>2</sup> Normally, in health, a band or zone of elevated pressure is interposed between the stomach and the esophagus. The resting pressures in the stomach are always in excess of those in the esophagus and, if there were no barrier between the two organs, material would flow retrograde from the stomach to the esophagus. However, during inspiration, the pressure over a band about 1.5 cm. wide, just below the point of respiratory reversal, is always greater than the pressure in the stomach. This band of increased pressure between the two organs represents the gastro-esophageal sphincter. It is the failure of this physiologic sphincter which results in the reflux of acid gastric juice into the esophagus and the commonest cause of sphincter failure is the sliding type of hiatal hernia. Malfunction of the physiologic sphincter has been demonstrated by studies in patients with hiatus hernia in which the pH of esophageal content is measured.<sup>8</sup> Unlike normal individuals there is free reflux of acid material for extended distances up the esophagus.

*From the Department of Surgery, University of Florida College of Medicine.*

*Presented at the 110th Annual Session of the Medical Association of Georgia, May 4, 1964, Macon, Georgia.*

*This work has been aided by N.I.H. Research Grant AM-02372.*

Repair of a hiatus hernia does not guarantee either complete relief of distress or prevention of peptic esophagitis. Smith and Bradshaw reported that 12 of the 73 patients (16.5%) treated by hiatus herniorrhaphy, exclusive of those with recurrences, were not completely relieved of symptoms following operation.<sup>7</sup> They have further pointed out that acid-pepsin regurgitation may still occur even though the esophagogastric junction is maintained below the diaphragmatic level.

Herrington has reported on 22 patients with sliding esophageal hiatal hernia who have undergone herniorrhaphy combined with a procedure designed to eliminate gastric hypersecretion, either vagotomy and pyloroplasty or vagotomy and excision of the gastric antrum.<sup>4</sup> Complete relief was achieved in 21 of the 22 patients.

The primary purpose of the present study was to determine whether or not surgical repair of a sliding esophageal hiatal hernia restores the competence of the esophagogastric sphincter. Second, it was planned to ascertain by laboratory as well as clinical evaluation whether or not the addition of ancillary surgical procedures is of value. Pyloroplasty was added in some patients to hasten gastric emptying, and hopefully to thereby reduce the residuum available for gastroesophageal reflux. Vagotomy was added in others, to reduce the secretion of acid gastric juice by the stomach.

Evaluation Performed

Clinical and radiologic evaluation was performed in all patients six months or longer postoperatively. In addition, esophageal reflux was measured by the method of Tuttle and Grossman.<sup>8</sup> A tube consisting of a polyethylene catheter and a pH electrode was passed into the stomach through the nasopharynx. Pressure was recorded continuously from the polyethylene catheter using a pressure transducer and a recording polygraph. pH was simultaneously recorded by attaching a pH meter to a separate channel of the polygraph. Two hundred cc. of N/10 hydrochloric acid were introduced into the stomach

through the polyethylene catheter, to insure a low gastric pH and to provide an adequate bolus for reflux. With the patient in the sitting position the tube was withdrawn in one centimeter increments. The level of the diaphragm was determined by inversion of intraluminal pressures during the respiratory cycle. Withdrawal into the esophagus was continued until the pH plateaued at a level approaching neutrality or until the pharynx was reached. The tube was then passed into the stomach again and the withdrawal repeated with the patient in the reclining position.

Results

A total of 43 patients are available for analysis. Follow-up varies from six months to five years and five months. Thirty-six of the 43 patients have been evaluated more than one year after surgery. A clinical history compatible with reflux esophagitis was present in all patients preoperatively. Upper gastrointestinal x-ray demonstrated a hiatal hernia preoperatively in 40 of the 43 cases. In the remaining three, reflux was demonstrated in the laboratory, confirming the clinical impression, and in all three a sliding hiatal hernia was demonstrated at surgery. Significant esophageal reflux was found in 35 of the 43 patients preoperatively. The examination was not performed before surgery in eight cases. There have been no cases with sliding hiatal hernia and esophagitis in whom gastroesophageal reflux has been found to be absent. Reflux is defined as a pH below 3.5 at a distance of 4 cm. or more above the diaphragm.

For the purpose of this report, the follow-up examinations are divided according to the type of surgery performed. Eighteen cases were treated by hiatal herniorrhaphy alone, seven by hiatal herniorrhaphy with the addition of a pyloroplasty, and 18 by hiatal herniorrhaphy with an added vagotomy and gastric drainage procedure.

The patients treated by hiatal herniorrhaphy alone are summarized in Figure 1. None of the 18 patients had a coexistent duodenal ulcer. Postoperative x-ray examination disclosed anatomically satisfactory repair in all. Thirteen of the 18 patients are essentially asymptomatic and are considered to have a good clinical result. It is of interest that eight of the 13 still show significant gastroesophageal reflux. Two patients have had persistent mild symptoms of esophagitis. These are less severe both in frequency and intensity than preoperatively, and both consider themselves much improved. Three additional patients, however, consider that their preoperative symptoms are unchanged since surgery and these must be considered surgical failures. Esophagoscopy in addition to x-ray examination shows no evidence for recurrent hiatal hernia. Thirteen of 18 patients treated by hiatal herniorrhaphy alone showed sig-

TABLE I

PATIENTS TREATED BY HIATAL HERNIORRHAPHY AND PYLOROPLASTY

Patients	Reflux		Clinical Results
	Pre-operative	Post-operative	
AS	+	0	Good
GH	+	0	Good
CJ	+	0	Good
JR	+	0	Good
LL	+	+	Good
VS	+	+	Fair
WA	+	+	Poor



GROUP I  
HIATAL HERNIORRHAPHY ALONE

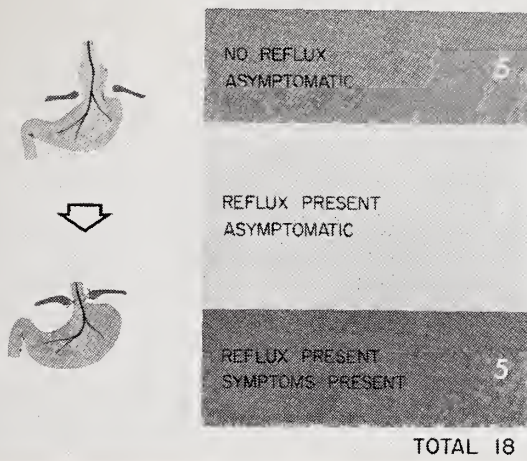


FIGURE 1

GROUP III - HIATAL HERNIORRHAPHY PLUS  
VAGOTOMY AND PYLOROPLASTY

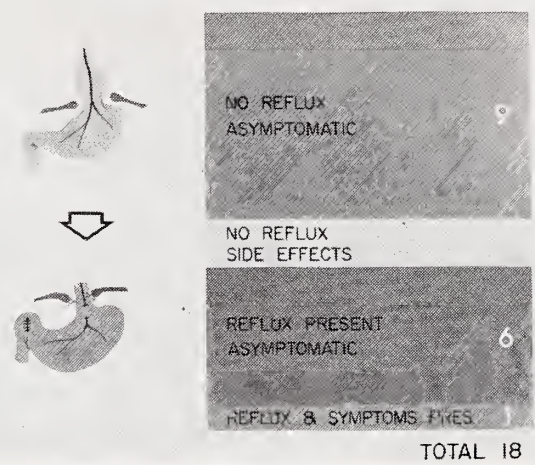


FIGURE 2

nificant gastroesophageal reflux postoperatively, indicating that surgical repair of the diaphragmatic defect did not restore competence of the esophago-gastric sphincter in 72% of this group.

### Seven Patients Treated

Seven patients were treated by hiatal herniorrhaphy and Heineke-Mikulicz pyloroplasty (Table I). None of the seven patients had a coexistent duodenal ulcer. Five of the seven patients are asymptomatic and can be considered to have a good clinical result. Only one of the five demonstrates significant gastroesophageal reflux postoperatively. A sixth patient has mild persistent symptoms of esophagitis and free gastroesophageal reflux is demonstrated by pH measurements. The seventh patient had complete recurrence of symptoms six months postoperatively. X-ray disclosed no evidence of recurrent hernia, although extensive reflux was found on laboratory study.

This group is too small to be of any analytic value, but suggests a lesser incidence of persistent reflux after pyloroplasty than where hiatal herniorrhaphy alone is performed. It is possible that this can be explained by a more rapid escape from the stomach of the hydrochloric acid bolus injected at the beginning of the study.

The 18 patients treated by hiatal herniorrhaphy in conjunction with vagotomy and a gastric drainage procedure are presented in Figure 2. This group is not entirely comparable to the others in that duodenal ulcer was present in 14 and basal gastric hypersecretion was known to be present in the remaining four. Again, pyloroplasty was the drainage procedure of choice; however, gastrojejunostomy was used in two and resection of the pyloric antrum with gastrojejunostomy was used in two others. Only one of the 18 patients has persistent mild symptoms of esophagitis, with reflux demonstrated. Fifteen are

classified as having a good clinical result. One patient is minimally handicapped by the immediate postprandial dumping syndrome. Another patient is virtually disabled by abdominal symptoms for which no cause has been demonstrated despite extensive study. It is of interest that only seven of the 18 patients demonstrate gastroesophageal reflux and six of these are asymptomatic.

### Discussion

When gastroesophageal reflux is measured by a direct recording of esophageal pH, surgical repair of a sliding esophageal hiatal hernia often fails to prevent reflux. In 23 of 43 patients an acid pH was found in the esophagus postoperatively. The fact that the majority of these patients are asymptomatic would lead one to suspect that there is a quantitative difference, and that the actual amount of reflux is less than that present preoperatively. There is a suggestion in the present study that gastroesophageal reflux may be less when a drainage procedure is combined with hiatal herniorrhaphy. Reflux was present in 72% (13 of 18) of patients treated by hiatal herniorrhaphy alone, whereas acid was found in the esophagus of 40% (10 of 25) of patients who had an additional pyloroplasty with or without vagotomy. It is possible that the hydrochloric acid bolus injected into the stomach at the beginning of study escapes distally. If this hypothesis is correct, it would constitute a valid clinical indication for the ancillary operative procedure.

### Fails to Restore

It seems clear that esophageal hiatal herniorrhaphy fails to restore the competence of the esophagogastric sphincter in approximately one-half of cases. Does the addition of vagotomy to reduce gastric secretion provide additional protection against the persistence or recurrence of peptic esophagitis? The



present study indicates that the additional surgery may improve the clinical results. In 18 patients treated by hiatal herniorrhaphy alone, five patients had persistence or recurrence of symptoms of esophagitis, and three of these must be considered unimproved. In the same number of patients treated by vagotomy and drainage procedure in addition to repair of the esophageal hiatus, only one has had persistence of symptoms referable to esophagitis. However, an additional two patients have a less than satisfactory result, related to new symptoms which must be attributed to the ancillary surgery. This indicates clearly that one must inevitably pay a price for increasing the scope of surgical treatment for this disorder.

The improved results observed in the group of patients treated by combined surgery are probably enhanced when one compares the preoperative state of these patients with those treated by hiatal herniorrhaphy alone. None of the latter group had a co-existent duodenal ulcer whereas 14 of 18 patients treated by vagotomy and pyloroplasty in conjunction with hiatal herniorrhaphy had a clearly demonstrated duodenal ulcer preoperatively, with the characteristic basal gastric hypersecretion. The most severe form of esophagitis, with its complication of stricture and hemorrhage, is known to occur with much greater frequency in patients who also have duodenal ulcer. This tends to make the favorable clinical results achieved in these patients stand in even sharper contrast.

In summary, peptic esophagitis should in all probability be considered as another manifestation of peptic ulcer disease. Its development is in all likelihood related in most cases to ablation of the normal closure mechanism at the esophagogastric junction, related to the occurrence of sliding esophageal hiatus hernia. Anatomic reduction and repair of the hernia failed to restore the competence of this sphincter in about half of the 43 patients studied by direct measurement of esophageal pH. Clinical results in the reported series indicate that the addition of vagotomy to reduce gastric secretion and a drainage procedure to hasten gastric emptying may be worthwhile adjuncts in the surgical treatment of this disease.

## BIBLIOGRAPHY

1. Allison, P. R.: Reflux Esophagitis, Sliding Hiatal Hernia, and the Anatomy of Repair. *Surg. Gynec. & Obst.*, 92:419, 1951.
2. Code, C. F.; Creamer, B.; Schlegel, J. F.; Olsen, A. M.; Donoghue, F. E., and Andersen, H. A.: *An Atlas of Esophageal Motility in Health and Disease*. Thomas, Springfield, Illinois, 1958.
3. Gould, D. M. and Barnhard, H. J.: Changing Concepts in the Structure, Function and Disease of the Lower Esophagus. *Am. J. Med. Sci.*, 233:581, 1957.
4. Herrington, J. L., Jr.: Hiatal Hernia with Esophagitis: Treatment by Hernia Repair, Vagotomy and Pyloroplasty or Antrectomy. *Ann. Surg.*, 151:812, 1960.
5. Lerche, W.: *The Esophagus and Pharynx in Action*. Thomas, Springfield, Illinois, 1950.
6. Neville, W. E. and Bartunek, R. R.: A Combined Medical and Surgical Approach to the Treatment of Reflux Esophagitis. *Am. J. G. E.*, 35:335, 1961.
7. Smith, L. C. and Bradshaw, H. H.: Esophageal Hiatal Hernia. *Surg. Gynec. & Obst.*, 109:230, 1959.
8. Tuttle, S. G. and Grossman, M. I.: Detection of Gastro-Esophageal Reflux by Simultaneous Measurement of Intraluminal Pressure and pH. *Proc. Soc. Exper. Biol. Med.*, 98:225, 1958.

## WYETH EXTENDS FELLOWSHIP PROGRAM FOR NINTH YEAR

Applications are now being received for Wyeth Pediatric Residency Fellowships that will begin on July 1, 1966. Sponsored by the Wyeth Fund for Postgraduate Medical Education, each of these fellowships provides \$4,800 over two years toward the advanced study required for Board Certification. Wyeth's monthly payments, made directly to recipients, are in addition to the normal stipends paid to residents by the institutions in which they train.

Eligible to apply are interns, physicians who have recently completed an internship, research Fellows, or physicians leaving the armed services or U. S. Public Health Service.

The Wyeth Pediatric Fellows must serve their residencies at any institution that is accredited by the AMA's Residency Review Committee of the Council on Medical Education and Hospitals, the American Board of Pediatrics, or the American Academy of Pediatrics.

A voluntary committee of distinguished pediatricians has the entire responsibility for selecting the Wyeth Pediatric Fellows. Requests for application forms and inquiries about the program should be directed to the committee chairman, Dr. Philip S. Barba, 120 Erdenheim Road, Philadelphia, Pa. 19118. Dr. Barba is Emeritus Associate Professor of Pediatrics at the University of Pennsylvania School of Medicine and past president of the American Academy of Pediatrics. All applications must be received by December 1, 1965.

Wyeth Laboratories inaugurated this Fellowship Program in 1958 to assist interns and young physicians who want to specialize in pediatrics, who have excellent records in scholastic achievements, who are citizens of the United States or Canada and are of good character, but who find it difficult to finance the required two years of postgraduate training.



# A STUDY OF THE EFFECT OF PHENERGAN AND VISTARIL IN COMBINATION WITH DEMEROL ON LABOR AND DELIVERY

**P**HENERGAN (PROMETHAZINE) has been reported as being: (1) A sedative in the early stages of labor; (2) In combination with Demerol, it provides analgesia, sedation, control of nausea and vomiting during labor, and a shortening of labor in both Multiparas and Primiparas; and (3) No untoward effects on the infant at birth. *Vistaril* (Hydroxyzine) has been reported as having: (1) Tranquillizing properties; (2) Ataractic properties; (3) Antiemetic properties in pregnancy and during labor; (4) It reduces the amount of narcotic to be used by as much as 50%; and (5) No untoward effect on the infant at birth.

It was our purpose to initiate a double-blind study to determine the following:

(1) If Phenergan and Vistaril used in combination with meperidine (Demerol) provides more effective sedation and analgesia than with Demerol alone.

(2) To determine if the amount of Demerol needed to obtain satisfactory sedation and analgesia is significantly reduced when used in combination with Phenergan and Vistaril.

(3) To determine if Phenergan and Vistaril have any effect on:

- reducing the incidence of nausea and vomiting during labor.
- the patient's memory of labor.
- shortening labor in multiparas and primiparas.
- the blood pressure after injection.
- the immediate postpartum condition of infants as measured by the Apgar score.

This study was done beginning January 15, 1964, and ended June 1, 1964. All staff patients admitted to the labor rooms of the Macon Hospital were placed on this study with the following exceptions:

(1) Those patients with complications which might affect the course of labor.

(2) Gestational age of less than 36 weeks.

\* Chief Resident, Department of OB-GYN, Macon Hospital

Presented at the 110th Annual Session of the Medical Association of Georgia, May 4, 1964, Macon, Georgia.

Hoyt C. Dees, M.D.,\* Macon

■ Favorable results are recorded in this double-blind study.

(3) Primigravidas with more than 8 cm. dilatation upon admission.

(4) Multigravidas with more than 6 cm. dilatation upon admission.

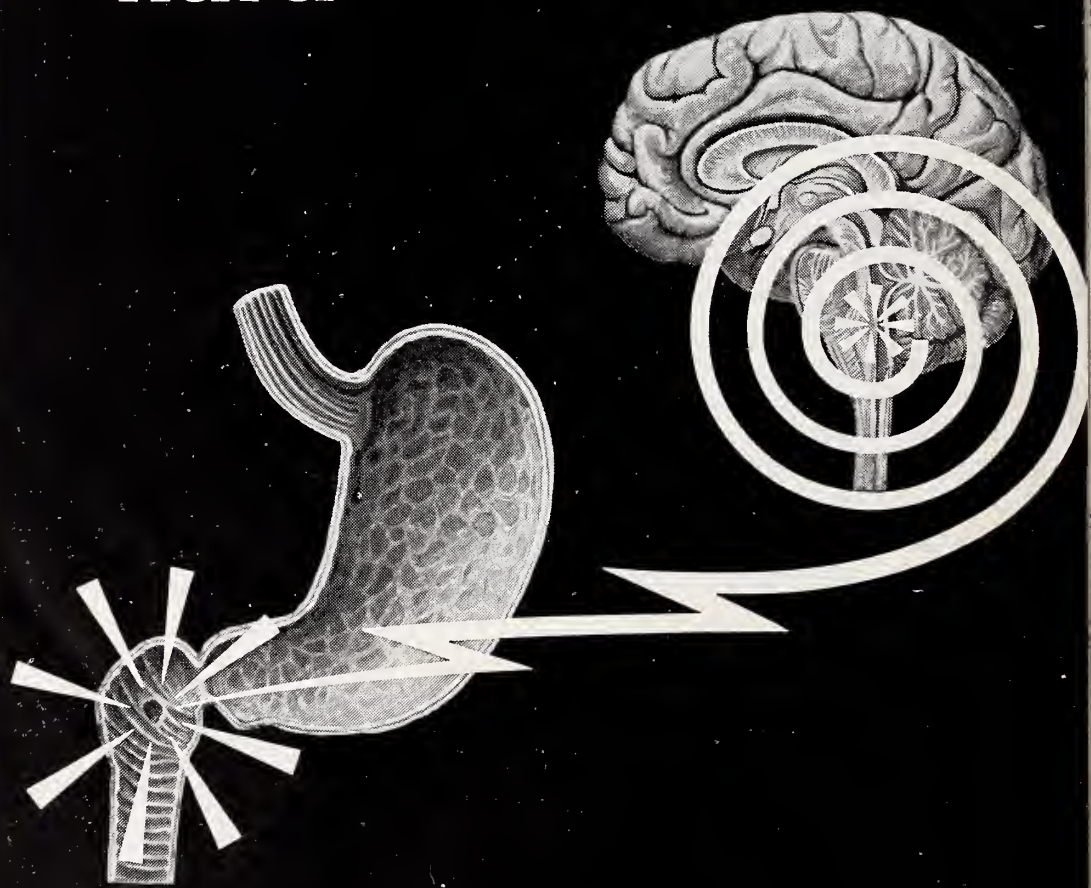
We used 10 cc. unmarked vials containing Phenergan, Vistaril, and Placebo. The concentrations of the first two drugs were 25 mg./cc. These unmarked vials were coded, labeled, and distributed by the Chief Resident who did not participate in the study.

Every patient received one or more injections of 3 cc. of the unknown drug along with 1 cc. (50 mg.) of Demerol as often as needed. The patients

TABLE I

	Placebo %	Demerol Plus Promethazine (Phenergen) %	Hydroxyzine (Vistaril) %
1. Quiet or Mild Verbal Behavior During 1st Stage of Labor	67.5	88.8	83
2. Cooperation During 1st Stage of Labor	81.3	88.8	94
3. Quiet or Mild Verbal and Physical Behavior During 2nd Stage of Labor	46.5	82.0	73.4
4. Cooperation During 2nd Stage of Labor	60.0	73.6	76.5
5. Meperidine 50 mgs. or Less, Total Dosage	34.8	62.5	53.1
6. Evaluation of Sedation and Analgesia at End of 1st Stage			
Very Good	2.3	26.4	14.0
Good	44.1	47.2	58.2
Fair	32.5	19.4	20.0
Poor	21.1	7.0	7.8

# when stress strikes hard





# PRO-BANTHINE<sup>®</sup> with DARTAL<sup>®</sup>

Each tablet contains: propantheline bromide  
(15 mg.) and thiopropazate dihydrochloride (5 mg.)

## **controls autonomic imbalance**

*Peptic Ulcer • Pylorospasm*

*Irritable Colon • Functional Gastrointestinal Disorders*

Firm control of both the psychic and visceral disturbances is indicated when emotional stress adversely influences gastrointestinal disorders. Pro-Banthine with Dartal has demonstrated its ability to provide such control.

Pro-Banthine, as expected, reliably moderates excesses of gastric secretion and gastrointestinal motility.

Dartal, a dependable, well-tolerated tranquilizer, calms the emotional turbulence that aggravates enteric disturbances.

Together, Pro-Banthine with Dartal offers twofold therapeutic access to a twofold clinical problem.

Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur with Pro-Banthine (propantheline bromide) and it is contraindicated in the presence of glaucoma or severe cardiac disease.

With Dartal (thiopropazate dihydrochloride) extrapyramidal and parasympatholytic symptoms have been reported and, rarely, leukopenia, erythematous skin reaction and allergic purpura. Do not administer to patients under the influence of alcohol, barbiturates or narcotics and use cautiously with sedatives, in epileptic or depressed patients or in those with liver damage. Reactions typical of phenothiazines may occur.

*Dosage:* One tablet three times a day.

**SEARLE**

P. O. BOX 5110, CHICAGO ILLINOIS 60680

*Research in the Service of Medicine*

TABLE II

	Placebo %	Demerol Plus Promethazine (Phenergen) %	Hydroxyzine (Vistaril) %
1. Patients Who Felt Pain Was Unbearable at End of 1st Stage	44.0	15.4	12.5
2. Patients Who Felt Pain Was Bad but Could Tolerate It at End of 1st Stage	56.0	84.6	87.5
3. Memory of Labor by Patients in Group 1 12 to 36 hours After Labor	91.5	66.6	81.4

TABLE III

	Placebo %	Demerol Plus Promethazine (Phenergen) %	Hydroxyzine (Vistaril) %
1. Length of 1st Stage of Labor Less than 12 Hours			
Primigravidae	83.3	72.7	81.25
Multipara	85.7	85.4	87.0
2. No Vomiting or Nausea During Labor and Delivery or for One Hour After Delivery	74.0	92.8	93.7

TABLE IV

	Placebo %	Demerol Plus Promethazine (Phenergen) %	Hydroxyzine (Vistaril) %
Apgar Scores On Infants:			
0	0.0	0.0	0.0
1-2	0.0	1.4	0.0
3-4	2.2	2.9	1.5
5-6	6.4	1.4	7.8
7-8	10.6	2.9	9.4
9-10	80.8	91.4	81.3

TABLE V

BLOOD PRESSURE ELEVATION AFTER ADMINISTRATION OF DRUGS DURING LABOR (B.P. 130/90)

Demerol Plus Drugs	Total	Pre- Eclamptic	Normal	% Elevation
1. Placebo	4	1	3	4.2
2. Promethazine (Phenergen)	28	12	16	27.6
3. Hydroxyzine (Vistaril)	18	11	1	11.3

received a total of 75 mgs. of Phenergan or Vistaril with each respective injection. All medication was given intravenously.

Observations were recorded on specially prepared data sheets. These data sheets were a slightly modified version of the "Behavior in Labor Rating Scale" developed by Miles Newton and Michael Newton and further modified by Byron Inman. These forms were attached to the patient's chart and data recorded by the Intern or Resident on duty at time of labor and delivery of each patient.

The total number of patients studied was 300. When the code was broken, the following was found: 100 patients received Placebo and Demerol; 98 patients received Phenergan and Demerol; and 102 patients received Vistaril and Demerol.

## Results

It was quite evident to the observers and also graphically as seen here in Table I and Table II that behavior, cooperation, and relief of discomfort was much improved in the groups receiving Phenergan and/or Vistaril with Demerol. Also significant was that better sedation and analgesia were effected with a reduced dosage of Demerol needed, as observed in Table I.

There was more amnesia or no memory of labor by the patients receiving Phenergan and/or Vistaril with Demerol as seen in Table II.

There was no statistical difference in the length of labor in either group, as evidenced in Table III.

The incidence of nausea and vomiting was significantly decreased in the Phenergan and Vistaril group as seen in Table III.

Apgar scores were similar in all three groups as observed in Table IV. All three groups average about 90% in the 7-8 and 9-10 Apgar classifications. There were no fetal deaths in this study.

Blood pressures were taken before, one minute after, five minutes, and ten minutes after injection. As seen in Table V, blood pressure elevations were noted in 27.6% of the Phenergan group; 11.3% of the Vistaril group; and 4.2% of the Placebo group. The elevations were transient, and no untoward effects were produced by these elevations. It was felt that the speed of injection was a primary cause of these elevations. Other studies such as those done by Daro, Gollin, Brenner, and Picchiatti of Chicago have noted elevations with Phenergan but no adverse effects. In studies by Sadove, LoPresto, Leazat, and Fitzgerald, they have noticed no significant elevation of blood pressure by Phenergan at all.

A study of the effect of Phenergan and Vistaril in combination with Demerol on labor and delivery was done on a total of 300 patients.

In Table I, the observers impression of sedation,



patient's behavior and cooperation, and amount of Demerol used with each unknown was recorded.

In Table II, the patient's own evaluation of sedation and analgesia was recorded.

In Table III, the length of the first stage of labor, and incidence of nausea and vomiting was recorded.

In Table IV, the effect of the Apgar scores was recorded.

In Table V, the incidence of elevation of blood pressure above 130/90 was recorded in normotensive patients after patients with toxemia of pregnancy or other hypertensive diseases were excluded.

The following conclusions were made:

(1) Sedation and analgesia was significantly better in the Phenergan and Vistaril group.

(2) The amount of Demerol necessary to obtain satisfactory sedation and analgesia was much less in the group receiving Phenergan and Vistaril.

(3) There was a significant reduction in the incidence of nausea and vomiting in the Phenergan and Vistaril group.

(4) Shortening of labor was not statistically significant in the Phenergan and Vistaril group.

(5) Phenergan and Vistaril cause no untoward effects on the infant at birth.

(6) There is some elevation of blood pressure noted in the Phenergan and Vistaril group, but this effect was of short duration and probably is related to speed of injections. There were no untoward effects noted as a result of these elevations.

We feel that Phenergan and Vistaril are excellent and effective drugs and both will continue to be used in our hospital.

I wish to thank Pfizer & Company for furnishing the drug, Phenergan, and for partial financial support of this study.

REFERENCES

1. Daro, A. F.: *Illinois State Med. J.*, Vol. 121, No. 1, Jan. 1962.  
2. Fitzgerald, Wm. F.: *Obst. & Gynec.*, 12:6, Dec. 1958.  
3. Inmon, W. B.: *Am. J. Obst. & Gynec.*, 86:853, Aug. 1963.  
4. Leazar, M. A., Capt., M.C., U.S.A.F.: *Western J. of Surg., Obst. & Gynec.*, 68:135, March-April 1960.  
5. LoPresto, Benjamin: *Western J. of Surg., Obst. & Gynec.*, 68:IV, Nov.-Dec. 1960.  
6. Newton, Michael, and Newton, Miles: *Obst. & Gynec.*, 15:28, 1960.  
7. Sadove, Max S.: *Obst. & Gynec.*, 19:784, June 1962.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

Ball, Larry T. Active—DeKalb	2910 N. Druid Hills Road Decatur, Georgia 30333	McLendon, F. Earl Active—Fulton	1370 Sharon St., N.W. Atlanta, Georgia 30314
Block, Rodney A. DE 2—Fulton	80 Butler St., S.E. Atlanta, Georgia 30303	Odom, W. S. Active—Muscogee	422½ Ninth St. Columbus, Georgia 31901
Branyon, Donald L., Jr. Active—Crawford W. Long	1010 Prince Ave. Athens, Georgia 30601	Purks, W. Warren, Jr. Active—Muscogee	Doctors Building Columbus, Georgia 30901
Callaway, George M., Jr. Active—Fulton	80 Butler St., S.E. Atlanta, Georgia 30303	Reid, William G. Active—Muscogee	934½ Front Avenue Columbus, Georgia 31901
Carney, Robert T. Active—Fulton	1170 Cleveland Ave. East Point, Georgia 30044	Rogers, Charles G. Active—Fulton	340 Boulevard, N.E. Atlanta, Georgia 30312
Clark, James E. DE 2—Fulton	1968 Peachtree Road, N.W. Atlanta, Georgia 30309	Skorapa, Victor, Jr. DE 2—Fulton	5386 Peachtree- Dunwoody Road Atlanta, Georgia 30305
Duggan, Mell L. Active—Bibb	839 First St. Macon, Georgia 31201	Soracco, Gerardo J. Active—Fulton	1311 Cleveland Ave. East Point, Georgia
Edwards, M. Delmar Active—Muscogee	622½ Eighth St. Columbus, Georgia 31901	Steves, Elma M. Active—DeKalb	3624 Chamblee-Tucker Road Chamblee, Georgia 30005
Goldman, Norman I. Active—Muscogee	Doctors Building Columbus, Georgia 30901	Talley, Robert E. Active—Muscogee	310 Doctors Building Columbus, Georgia 30901
Greenberg, Joel I. Active—Fulton	4558 Roswell Road, N.W. Atlanta, Georgia 30305	Thomas, Marcus C. Active—Bibb	2009 Vineville Avenue Macon, Georgia 31204
Hardman, William J. Active—Crawford W. Long	740 Prince Ave. Athens, Georgia 30601	Tutsch, Wilbert R. Active—Fulton	1311 Cleveland Ave East Point, Georgia
Hightower, Samuel J. Active—Bibb	740 Hemlock St. Macon, Georgia 31201	Uzee, Edward P. Active—Fulton	384 Peachtree St., N.E. Atlanta, Georgia 30308
Iseael, Philip Z. DE 2—Fulton	1170 Woodland Ave., N.E. Atlanta, Georgia 30324	Waldes-Castillo, Esteban J. Active—Baldwin	Milledgeville State Hospital Milledgeville, Georgia 31062
Jacobs, L. Davis Active—Ware	1921 Alice St. Waycross, Georgia 31501	Walker, Charles O. Active—Richmond	Talmadge Memorial Hospital Augusta, Georgia 30901
Knowlton, J. Wade DE 2—Fulton	80 Butler St., S.E. Atlanta, Georgia 30303	Vickoren, Angvald Active—Fulton	340 Boulevard, N.E. Atlanta, Georgia
Levine, Michael K. Active—Fulton	6363 Roswell Road Atlanta, Georgia 30328	Wilkerson, Bernie J., Jr. Active—DeKalb	2508 Carroll Ave Chamblee, Georgia 3005

# RECURRENT APPENDICITIS AFTER "APPENDECTOMY"

James R. Shamblin, M.D.,\* *Tuscaloosa, Alabama*

Thomas L. Hudson, Major, MC, *Fort Benning, Georgia*

## ■ A McBurney scar can sometimes lead to false assumptions.

**R**IGHT LOWER QUADRANT pain may present a perplexing problem, especially when it is assumed that the appendix is no longer present. This assumption can be erroneous as illustrated by the following case report.

### Case Report

This 24-year-old colored male was admitted to the Martin Army Hospital complaining of right lower quadrant pain for the 24 hours prior to admission. He was awakened with a sharp, constant pain over a healed incision in the right lower quadrant, and he noted that the area was swollen and tender to touch.

The patient states that he had a ruptured appendix on December 8, 1960, at which time he underwent an appendectomy at another hospital. He noted a drain in the incision, and it was gradually removed over five days. He was in good health from that time until July 10, 1961, at which time he had nausea, vomiting, fever, and pain and tenderness in the right lower quadrant. He was admitted to the same hospital as previously. On admission his abdomen was slightly distended and tender over the McBurney scar. A barium enema was done and showed no obstruction, with passage of the barium into the distal ileum. The fundus of the cecum was somewhat irregular suggesting an abscess in the right iliac fossa. He underwent an exploration through the old incision on July 20, 1961, and an abscess was incised and drained.

Since that time he has had two similar episodes

*From the Department of Surgery, Martin Army Hospital, Fort Benning.*

*\* Dr. Shamblin is now in private practice at 225 9th Street, East, Suite 205, Tuscaloosa, Alabama.*

with spontaneous drainage of purulent material from the McBurney scar.

Physical examination revealed a well-developed colored male complaining of lower abdominal pain. Blood pressure was 120/80, temperature, 102, pulse 88. Significant physical findings were limited to the abdomen. A classical McBurney incision was present in the right lower quadrant. The middle portion of the scar was tense, tender, and warm to touch with a small area of fluctuation. He had diffuse tenderness and rebound in the right lower quadrant with some tenderness in the other abdominal quadrants. Bowel sounds were hypoactive. Rectal examination revealed tenderness on the right and a questionable mass on the right.

Laboratory Data: Urinalysis normal; white blood count 12,200 with 84 neutrophils, 15 lymphocytes, 1 monocyte; hematocrit 43%; serology nonreactive. Culture from the abscess revealed *Pseudomonas aeruginosa*, sensitive to Streptomycin, Erythromycin, and Kanamycin.

Chest x-ray was normal. A flat plate of the abdomen revealed several dilated loops of small bowel primarily in the left upper quadrant and mid abdomen. There was also some gas scattered throughout the proximal portion of the colon.

### Appendix Found

The patient was started on intravenous fluids and antibiotics. It was the impression that he had a recurrent wound abscess most likely being perpetuated by a cecal fistula secondary to his initial operation. He was taken to the Operating Room and a lower midline incision was made. Exploration revealed the cecum and distal ileum to be part of an inflammatory mass in the right lower quadrant. Dis-



section in this area revealed a small abscess pocket adjacent to the cecum and upon further dissection the entire appendix was found to be present and acutely inflamed. Its distal portion extended nearly through the entire abdominal wall in the previous McBurney scar. There was a small perforation in the wall of the appendix at its junction with the parietal peritoneum. The appendix was dissected free in its entirety and removed. A stab wound was made through the old scar and a Penrose drain led into the area of the abscess. One gram of Kanamycin and 100 cc. of normal saline were instilled into the pelvis and the laparotomy wound closed.

### Pathology Report

The specimen consists of an appendix measuring 5 cm. in length. The distal end is dilated and contains some organizing exudate on the serosal surface. On sectioning through the appendix, the wall is thickened and somewhat yellowish and soft. A small perforation is noted at the junction of the middle and distal third. Microscopic Diagnosis: Acute appendicitis with perforation.

The patient had a totally uneventful postoperative course and has had no further difficulty with drainage from his incision.

The presence of a McBurney scar in the right lower quadrant in a patient does not necessarily rule out the possibility of acute appendicitis as illustrated by this case.

Records of this patient's previous hospitalizations were obtained and showed that at his initial operation he had an appendiceal abscess treated only by incision and drainage. The appendix was not removed. As the drain was withdrawn, the tip of the appendix followed it through the incision until it lay just beneath the skin. Recurrent attacks of appendicitis occurred and presented as abscesses in the abdominal wall.

If this patient had been aware of the true nature of his original operation, the diagnosis could have been made and the condition properly treated at his first recurrence.

Persistent or recurrent wound infection after appendectomy is usually caused by a retained foreign body or a fistula which communicates with the bowel. In our case the subcutaneous location of the appendix served as both a "foreign body" and a fistulous tract from the cecum to the skin. We have been unable to find a similar case in reviewing the literature for the last several years.

### Summary

A 24-year-old colored male was admitted to the hospital with a history of recurrent wound abscesses and an "appendectomy" scar. Exploration revealed the appendix to be partially protruding through the abdominal wall and to be acutely inflamed. The appendix was removed and the patient has had no further difficulty with wound abscesses.

## MILITARY DEPENDENTS MEDICAL CARE

### Schedule of Maximum Allowances

The Medical Association of Georgia, acting as state fiscal administrator, has maintained a schedule of maximum allowances for participating Georgia physicians who render medical care to eligible dependents of members of the U. S. Uniformed Services (Army, Navy, Air Force, etc.) under the provisions of the "Dependents' Medical Care Act of 1956." MAG has negotiated this maximum schedule of allowances with the federal government so that claims may be reimbursed according to the regulations of the law.

In general there have been two major points of concern which are: (1) communication with Georgia physicians as to the actual amounts of maximum allowance for given medical procedures; and (2) the determination of *current* maximum allowances on a state-wide basis that do in fact actually reflect the physician's usual charges based on a serviceman's average annual income of \$4,500.00.

### Permission for Dissemination

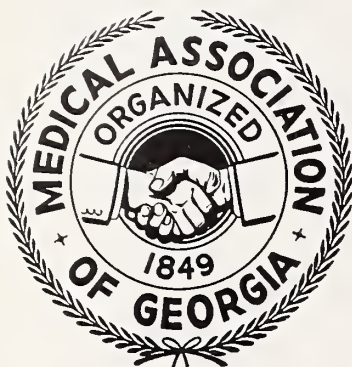
At the request of the MAG Council, the federal government has amended the MAG contract to permit the dissemination of the actual amount allowed by the government for any given medical procedure. At the inception of this program, this was permissible but some years later the government made it illegal to give

out such information to participating physicians. With this new contract change, it is now permissible to give out this information at the request of the individual physician. Therefore, any Georgia physician may request by letter to MAG the present maximum allowance for any given medical procedure covered under this program.

The MAG House of Delegates meeting May 4, 1965, set up a "negotiating committee" of MAG to be composed of representatives of each "specialty society" including the Georgia Academy of General Practice. This committee is charged with compiling all MAG fee schedules with third parties subject only to approval of MAG Council. The maximum schedule of allowances under the Dependents' Medical Care Act will be of primary concern to this new "negotiating committee" when they meet in September of this year—and the committee recommendations will become the basis for MAG in negotiating the 1966 contract with the government for this program. Therefore, physicians concerned with this aspect of the program are urged to contact their specialty society officers to make their views known to the society representative on this new "negotiating committee." In this way, all schedules may actually represent current practices throughout the state.

# 1966 Annual Session

May 8-10, 1966 – Columbus, Georgia



## First Call for Scientific Papers

All titles must be submitted to the  
respective program chairmen listed  
below before November 1, 1965

### SPECIALTY SOCIETY SCIENTIFIC SECTION PROGRAM CHAIRMEN

#### ANESTHESIOLOGY

Dan C. Newberry, M.D.  
Doctors Building  
Columbus

#### CHEST

Robert H. Vaughan, M.D.  
Physicians Building  
Columbus

#### DIABETES

Harry Brill, M.D.  
Doctors Building  
Columbus

#### DERMATOLOGY

Edgar B. Smith, M.D., Major, (MC)  
Martin Army Hospital  
Ft. Benning, Georgia

#### GENERAL PRACTICE

George D. Schuessler, M.D.  
Doctors Building  
Columbus

#### MEDICINE

Simone Brocato, M.D.  
Physicians Building  
Columbus

#### OBSTETRICS AND GYNECOLOGY

John R. McCain, M.D.  
384 Peachtree Street, N.E.  
Atlanta

#### OPHTHALMOLOGY AND OTOLARYNGOLOGY

Lionel Yoe, M.D.  
Doctors Building  
Columbus

#### ORTHOPEDICS

George Whatley, M.D.  
1316 13th Avenue  
Columbus

#### PATHOLOGY

Agatha Thrash, M.D.  
St. Francis Hospital  
Columbus

#### PEDIATRICS

A. J. Kravtin, M.D.  
204 11th Street  
Columbus

#### PSYCHIATRY

Leonard T. Maholick, M.D.  
1327 Warren Williams Rd.  
Columbus

#### RADIOLOGY

George M. Hutto, M.D.  
1444 Fourth Avenue, Columbus

#### SURGERY

S. A. Roddenbery, M.D.  
711 Center Street  
Columbus

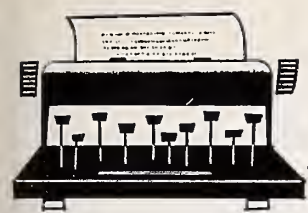
#### UROLOGY

Franklin D. Edwards, M.D.  
1430 Third Avenue  
Columbus

#### PUBLIC HEALTH

Joe A. Bain, M.D.  
P. O. Box 2299  
Columbus





## The New Medicare Law

**T**HE SOCIAL SECURITY Amendments of 1965, better known as "medicare," was signed into law on July 30. Suffice it to say that this law is one of the most comprehensive and complex pieces of legislation ever enacted.

### Four Titles

This law has four titles. Title I is concerned with health insurance for the aged and has two parts. Part 1 has three subparts, namely: Part A which establishes a hospital insurance program, patterned after the King-Anderson bill; Part B establishes a voluntary federally administered medical insurance program to provide benefits which supplement the benefits of the King-Anderson program; and Part C contains definitions and provisions relating to the administration of Parts A and B. Part 2 of Title I establishes a new program which will replace the existing programs for medical assistance under the public assistance programs.

Title II amends the Maternal and Child Health and Crippled Children's programs; extends the grant program for mental retardation planning; amends the public assistance programs to authorize federal participation in assistance to aged individuals with tuberculosis or mental disease; and authorizes appropriations for a study of resources for the diagnosis and prevention of emotional illness in children.

Title III makes numerous amendments to the Old-Age and Survivors Insurance and Disability Insurance programs under the Social Security Act, including compulsory coverage for physicians retroactive to January 1, 1965; payments for non-permanent disability; and increases in the taxable wage base and tax rate. Title IV amends the public assistance programs to provide, among other things, increases in the federal contributions for the programs.

This new multi-purpose law, now known as Public Law 89-98, contained in some 138 pages of "fine print" defies specific interpretation at this time. As with any complex law, regulations yet to be determined will spell out the ways and means in which the law will be administrated. On July 30, the Amer-

ican Medical Association issued the following press release after meeting with President Johnson:

"We will watch developments in this new program and offer constructive suggestions, both to Congress and to the Administrators of the program, in the interest of the maintenance of the highest quality of medical care.

"President Johnson has requested that we meet with officials of the Department of Health, Education and Welfare on the development of rules and regulations.

"Following our Conference with Mr. Johnson on Thursday, initial meetings were held with HEW Secretary Anthony Celebrezze, exploring arrangements for AMA and HEW review of projected regulations and of problems of administration and interpretation of the law.

"The President also asked that we report back to him in two months on our progress."

### All Matters to Be Considered

The AMA has indicated that all these matters will be considered by a special meeting of the AMA Board of Trustees on August 7. And so a new law goes into effect—legislation that was opposed by organized medicine, with ramifications and complexities that are a question mark at this time. It is of interest to note that the Hospital Insurance Benefits provisions (King-Anderson) take effect July 1, 1966, with the exception of "post hospital extended care services which become effective on January, 1967. Effective date for benefits under the Voluntary Supplementary Insurance Plan (covering physician's services, home health services, etc.) is July 1, 1966.

As soon as interpretations of the law are resolved; as soon as regulations are promulgated and defined; as soon as the profession's relationships to this far reaching program are clarified—MAG will "communicate" any and all data to the physicians of Georgia so that each doctor will know all the facts. Complete coverage will be given in the *MAG Journal*, *MAG Newsletters*, and the *AMA News*.

## The President's War on Heart Disease, Cancer and Stroke

PENDING in the Congress is a little known and less understood bill which is said to be more far reaching than the ill-conceived "medicare" bill recently enacted. Officially it is known as the "Heart, Cancer and Stroke Amendments of 1965"—loosely it is referred to as the President's "war" on killer diseases. Its genesis is the so-called DeBakey Commission Report, so named for its Chairman, Dr. Michael DeBakey, head of the Department of Surgery at Baylor University's College of Medicine, Houston, Texas.

### In Essence

In essence the bill proposes to create a series of "regional medical complexes" to help fight heart disease, cancer, stroke and other major, though unnamed, diseases. At the center of each regional complex would be a medical school and an affiliated teaching hospital. Surrounding the center would be a group of satellite community hospitals throughout the area which would be engaged in diagnosis, treatment and clinical research in the three named diseases.

Technically a "regional medical complex" would be defined as a group of public or non-profit institutions each of which is engaged in research, training, diagnosis, and treatment relating to heart disease, cancer, or stroke, and at the option of the regional complex, any other disease found by the Surgeon General to be of major significance to the objectives of the complex.

The bill (actually two bills, S. 596 and H.R. 3140) is currently pending in the House Interstate and Foreign Commerce Committee where hearings were completed approximately 30 days ago. In the Senate S. 596 has already been passed; in fact passed with such haste as to suggest that the "world's most deliberative body" neither understood it nor was it particularly concerned for its cost or its far reaching and potentially dangerous ramifications.

### The Vagueness of the Proposal

No one can voice any well-founded criticism of the ostensible objectives of this legislation; namely to reduce and possibly eliminate the incidence of, and death from, these dread diseases. One can and should, however, voice objections to the vagueness

of the proposal and to some of the methods which the bill would employ.

"Medicare," for all of its attendant evils, was fairly specific and consumed the better part of 400 pages in length. The medical complex bill, however, is less than 12 full pages and is so fuzzy and nebulous as to defy meaningful Congressional intent. In short, if this bill were enacted in its present form, no one, including the Congress itself, would know specifically what had been authorized. A couple of things are clear, however. The bill would be costly, it would drastically re-orient medical practice in this country and the bill plainly has more deficiencies than it has merits.

### The Deficiencies

What are some of the major deficiencies of this proposal? First there is the question of available medical manpower to meet the needs of the complexes. If a significant number of physicians are to be diverted from their major concern, which is the total medical care of the patient, to the limited concern of heart disease, cancer and stroke, then it is obvious that a faulty distribution of medical manpower will follow, thus intensifying the problem created by the reduction in general practice. In addition, the growth of the complex would tend to discourage physicians from locating in rural areas away from the influence of the complex. Such a condition would further poorly distribute doctor manpower in areas most severely affected by present distribution trends.

One of the chief arguments made by the DeBakey Commission and others advocating this proposal is that there is a serious time lag between new scientific discovery and its application by medical practitioners. Their reasoning proceeds to say that a system of communications between the medical complex and practitioners in the hinterlands is needed to eliminate the so-called "time lag" between discovery and application. This presumably would be accomplished by a cadre of roving emissaries from "medical complex central" to groups and individuals in outlying areas. A curious aspect of this particular recommendation by the Commission is that its own Subcommittee on Research has stated that "there



has been no major breakthrough accomplished by research related to cancer, heart disease and stroke which currently awaits application." This "time lag" argument certainly appears to have been made without any basis in fact, as most all will agree that there must be a time interval in which new diagnostic and therapeutic developments are evaluated by physicians in relation to their own patients.

### The Adverse Effect

Beyond these points there is the question of adverse effect the creation of the medical complexes would have on hospitals which do not become a part of the complex: not to mention the detrimental effect on those medical schools which are not given

a leadership role in the program. In both cases the "chosen few" would have a great competitive advantage over those not so chosen, and the result would likely be the deterioration of those "on the outside looking in."

As this paper is written we are told that the House Interstate and Foreign Committee is not presently disposed to do anything with this bill during the 1965 session of Congress. But rather it would prefer to wait until the matter is more thoroughly explored and a public dialogue developed. This, however, is an Administration bill and this Congress has shown a remarkable reluctance to deny the President any program he has asked for no matter how hastily thrown together, how vague, costly, or ill-conceived it might be.

## The Physician's Responsibility In Mental Health Programs

THE PHYSICIAN traditionally has been the first line of defense against mental illness. This is certainly as it should be, in view of the central importance of medicine in the diagnosis and treatment of mental illness. More than half of the patients seen by the family physician come with problems which have emotional as well as physical components. This inter-relationship often makes diagnosis and treatment a very complex matter, and improved methods of treating the mentally ill and preventing mental illness are urgently needed.

There is a serious shortage of manpower in the psychiatric field. Non-psychiatric physicians must

help fill this void, both by utilizing psychiatric methods in their work, and by becoming involved in Comprehensive Community Mental Health Programs. Physicians must not only become involved in such programs but must do so in a position of leadership. This leadership must be vigorous, or by default, other disciplines will take over, resulting in a less effective level of patient care.

Every physician in Georgia should become thoroughly familiar with mental health programs planned for his area and lend his leadership and experience to such programs.

1114 Vine Street, N.E.  
Gainesville, Georgia 30501

## "It Takes a Smart Doctor To Stay Out of God's Way"

WE, THE EDITORS of your *Journal*, think it is time to break precedent and extoll the virtues of the living rather than write mawkish sentiments over the dead. And, thus, we believe Dr. Hugh Wood of Atlanta deserves a commendation. A commendation on his retirement to the practice of medicine, not from it.

Coming down from the mountains of West Virginia to "read medicine" in Tidewater Virginia, he brought with him that keen wit and quick observation accompanying an earthy humor and compassion

that have remained with him through these 43 years of teaching and practicing medicine. The observation that he often made, that, "It takes a smart doctor to keep out of God's way," is a part of the heritage he brought with him.

### Georgia and Beyond

While he has resided, taught, and practiced medicine in Atlanta all of these years, his influence has been felt, and his friends are spread over, the entire

## EDITORIALS / Continued

state of Georgia, and even beyond. Dr. Wood is leaving Emory University Medical School and Clinic to practice medicine in the middle Georgia community of Griffin. Many of his students (and we mean those of us who have been touched by his graceful guidance, by both precept and example) have, with his consent, begun a fund that will pay for a portrait of him to be placed in the Emory

University Medical School. Only a maximum of \$10.00 will be accepted from any individual.\*

History has a way of reducing men to paragraphs; they often cover dreams with dust. This will not be true of Dr. Hugh Wood, because, "The quiet mind is richer than a crown."

*1293 Peachtree Street, N.E.  
Atlanta, Georgia 30309*

*\* Contributions can be sent to Dr. Cyrus W. Strickler, Jr.*

## 1965 CALENDAR OF MEETINGS

### State

September 20-21—Seventeenth Annual Scientific Session of the Georgia Heart Association, Biltmore Hotel, Atlanta.

September 23—The Greater Atlanta Cancer Symposium, sponsored by the Cobb County Medical Society, the Cobb County Dental Society and the American Cancer Society, Georgia Division; Auditorium on the Mall, Cobb County Center, Marietta.

September 27-October 1—Five Days of Internal Medicine, sponsored by the Department of Medicine, Emory University School of Medicine, Grady Memorial Hospital, Atlanta.

October 1-2—Medical College of Georgia Alumni Day, Augusta. For further information write: The Dept. of Continuing Education, the Medical College, Augusta.

October 27-30—Second Annual Institute on Group Behavior and Group Leadership, sponsored by the Department of Psychiatry, Emory University School of Medicine, Holiday Inn, Callaway Gardens, Pine Mountain, Ga.

For 1965: Postgraduate Courses sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.

October 14-15—Whitfield County Medical Symposium, Dalton, Ga.

September 29-December 15—Psychosomatic Medicine (12 weekly evening sessions)

November 15-19—General Practice Review:

November 15—OB-GYN

November 16—Internal Medicine

November 17—Endocrinology

November 18—Cardiology (a.m.)  
The Eye (p.m.)

November 19—Pediatrics

December 1-2—Fractures

December 7-May 12—Georgia Circuit Course (six sessions one day each month at six centers in Georgia)

May 8-10, 1966—112th Annual Session of the Medical Association of Georgia, Columbus.

### Regional

September 20-24—American College of Physicians presents Postgraduate Course No. 1, "Basic Mechanisms in Internal Medicine," Medical College of Virginia, Richmond, Va.

September 27-28—Tennessee Valley Medical Assembly, Tivoli Theatre, Chattanooga, Tenn.

October 7-9—American College of Physicians (Third Fall Meeting), Deauville Hotel, Miami Beach, Fla.

October 10-13—Medical Society of Virginia, John Marshall Hotel, Richmond, Va.

October 14-16—Pediatric Postgraduate Seminar, College of Medicine, University of Florida, Gainesville, Fla.

October 15-17—American Heart Association, Americana Hotel, Bal Harbour, Fla.

October 21-29—American Occupational Therapy Association, Americana Hotel, Bal Harbour, Fla.

October 24-27—American College of Gastroenterology, Americana Hotel, Bal Harbour, Fla.

October 29-30—Symposium on Common Problems in General Practice—Office Procedures, sponsored by the Mound Park Hospital Foundation, Florida Academy of General Practice (16th Annual Scientific Assembly), St. Petersburg, Fla.

November 1-4—Fifty-Ninth Annual Meeting of the Southern Medical Association, Houston, Texas.

November 1-4—Annual Meeting of the Section on Otolaryngology of the Southern Medical Association, Houston, Texas.

November 3-5—American Society of Tropical Medicine and Hygiene, Jung Hotel, New Orleans, La.

November 3-5—Tennessee Academy of General Practice, 17th Annual Scientific Assembly, Gatlinburg Auditorium, Gatlinburg, Tenn.

November 17-20—International Conference on Hyperbaric Medicine (3rd), Duke University Medical Center, Durham, N. C.

December 7-9—Southern Surgical Association, Homestead, Hot Springs, Va.

### National

September 15, 1965-June 15, 1966—A nine month tutorial program in Cardiology offered by the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

November 15-18—Interstate Postgraduate Association of North America, Cleveland Assembly, Cleveland, Ohio.

November 19-22—1965 Annual Meeting of the National Society for Crippled Children and Adults (The Easter Seal Society), Palmer House, Chicago.

November 28-December 1—American Medical Association (Clinical Convention), Philadelphia.





# MEDICINE AND RELIGION

EVER SINCE George Alexander asked me to write this page, and especially designated this subject, a considerable amount of "spare-time" thinking and reading has been done along the lines of medicine and theology. Also included have been conversations with ministers. When one's interest is diverted to a particular idea, it is amazing how much can be found pertaining to the subject. Without making any real diligent search, a number of articles related to this subject have been found recently in the *AMA News*, *Medical Tribune*, *JAMA*, *Medical World News*, and *The National Observer*. A news item carried the story of the program sponsored by the AMA Department of Medicine and Religion held in conjunction with the AMA Annual Convention in New York. It is readily apparent that there is no lack of available information concerning the relationship existing between medicine and religion.

## From Medical History

Innumerable examples can be cited from medical history indicating the attitude of physicians in earlier times toward the spiritual aspect of human illness. Pythagoras, the Greek physician, stated in the sixth century B.C. that the noblest task one could undertake in this world was to teach men how to live. Later, Hippocrates said, "When one has fallen ill, one must change one's way of life." Two quotations from the "father of modern surgery," Ambroise Pare, are particularly appealing—"I tended him, God healed him," and "One cannot love medicine without loving man." More recently Dr. Howard Rusk stated, "The physician has always possessed a fourth dimension in professional practice—the doctor-patient relationship that is more potent than antibiotics and as incisive as surgery."

In the illness of a human there are three facets to be considered—the physical, the emotional, and the spiritual. This is true whether the human is adult or child, whether surgical or non-surgical, whether serious or mild, whether long-term or acute, whether

terminal or convalescing. *No practicing physician can escape contact with these three elements of human illness.* Therefore, it behooves all of us to think about this whole area of medicine and religion.

## Tremendous Advances

Everyone is aware of the tremendous advances that have occurred in treating the physical aspect of human illness. It would be insulting the reader's intelligence to herewith list the absolutely phenomenal advances that have been made in the past 50 years in therapeutics, instruments, techniques. Equally impressive are the advances having been made, and currently continuing, in the field of approaching and treating the emotional aspects of human illness. In these two areas medical science has been, and is doing, a superior job.

What is taking place in relation to the spiritual aspect of human illness? One deleterious thing has gradually been occurring. With the more scientific approaches now available, the quicker cures, and the more and more impersonal attitude of the physician there has been a tendency for physicians to increasingly neglect the spiritual aspect. This is not intended to indict all physicians, but a sizeable number of physicians are certainly guilty of this neglect. There are some encouraging things, however, taking place. As mentioned above, programs on medicine and religion have been sponsored on a national level. Your MAG has a subcommittee on Medicine and Religion. Several county medical societies have held joint meetings with local ministerial associations. Clergymen in many denominations are becoming increasingly aware of the problem and are taking steps to provide more and more help in this area. Hospitals in some of the larger cities are staffing their chaplain's department with full time chaplains, and many of the smaller hospitals have a rotating system whereby the members of the local ministerial association voluntarily serve as hospital chaplain. It seems that from the hospital standpoint some prog-

ress is being made, and undoubtedly will accelerate over the next several years.

### The Non-Hospitalized Patient

However, what about the patient who is not hospitalized? Does he need spiritual help any the less? In many instances he probably needs support in this realm more than many of the people who are in the hospital. Conversation with a minister recently indicated that on a particular day he had 14 of the members of his church in the local hospital. The total membership of this church is about 1,400. Surely, on any one day there will be more than one

percent of his membership that is ill. The big problem, then, is how is one going to get around to all the others? At least one conclusion to which I have come concerning this extremely important area in caring for the sick is that there must be increasing communication between physician and clergyman. This should start with each physician establishing a very personal relationship with his own minister. After this can come the county society liaison committees, the state and the national endeavors.

You have read of the problem. One possible remedy is suggested.

*What is your solution?*

*Henry S. Jennings, Jr., M.D.  
First Vice President,  
Medical Association of Georgia*

## MICHIGAN STATE MEDICAL SOCIETY WILL CELEBRATE CENTENNIAL IN SEPTEMBER AT DETROIT

The Michigan State Medical Society will celebrate a century of service in medicine at its Centennial Session in Detroit, September 19-24, with headquarters at the Sheraton Cadillac Hotel.

Keen interest has been created throughout the mid-west in the early plans for the Centennial. Invitations have been extended to physicians in adjacent states and in neighboring Ontario and to the top officials of each state medical society, and to national officers of the AMA and ancillary medical organizations.

"Daily themes have been developed and each day will be a convention in itself, replete with scientific, professional and social events," declares Oliver B. McGillicuddy, M.D., Lansing, President of the Michigan State Medical Society.

Following is the six-day plan:

- Sunday, September 19  
Medicine and Religion Day
- Monday, September 20  
Medicine and Business, Industry  
and Communications Day
- Tuesday, September 21  
Medicine and Medical Organization Day
- Wednesday, September 22  
Medicine and Science Day
- Thursday, September 23  
Medicine and Voluntary Health Day
- Friday, September 24  
Medicine and Government Day

The MSMS Council has approved some unique activities for the Centennial Session, which is being directed by C. Allen Payne, M.D., Grand Rapids, general chairman. Following are only a few:

The activities will open with an impressive Medicine and Religion Convocation, open to the public and the profession, at 3:00 p.m., Sunday, September 19 at the big Ford Auditorium in Detroit. Speakers will include William Menninger, M.D., president of the Menninger Foundation, Topeka, Kansas, and the Rev. Dr. Paul

McCleave, director of the AMA Department of Medicine and Religion. The members of the MSMS House of Delegates will sit in session at this program.

The first business session of the Michigan House of Delegates, Sunday evening, will hear an address by Walter Judd, M.D., former Congressman from Minnesota.

Michigan medicine will pay tribute Monday, September 20 to twenty-three representative corporations in the fields of Business, Industry and Communications. Speaking at this awards luncheon will be Austin Smith, M.D., executive director of the Pharmaceutical Manufacturers Association.

The MSMS scientific program will begin at noon Tuesday and continue through Friday at Cobo Hall. The scientific program each day will utilize general assemblies, scientific luncheon programs, breakfast discussion groups, closed-circuit color-television, clinical demonstrations, scientific and technical exhibits, conferences, seminars, et al.

Many allied scientific organizations will hold their own brief meetings on Wednesday, September 22 and then participate in the MSMS scientific offerings. Added attractions will include a Diet Therapy Conference and a National Health Careers Symposium.

Physicians and invited guests on Friday, September 24 will explore "Medicine's Role in Government and Government's Role in Medicine." The panel will include Congressman Durward Hall, M.D. Also on the day's schedule is a general assembly on preventive medicine, the Governor's Luncheon with George Romney and awards to physicians who are outstanding in public service.

The Michigan State Medical Society has developed an extensive informational program to bring the Centennial Session to the attention of both the medical profession and the general public. Mailing pieces, radio and television programs, newspaper features, a Centennial film, special art work, etc., are being utilized to the fullest.





## VIRAL PERICARDITIS

Daniel R. Turner, M.D., *Decatur*

THE SEROUS MEMBRANE that envelops the heart is subject to a variety of insults and afflictions. One of the most common of these is a clinical complex which, in the past, has usually been called "acute benign pericarditis."

In recent years, viruses have often been implicated as causative agents in "benign" inflammations of the pericardium. The theory of viral cause is a good one, but, with the notable exception of Coxsackie B, proof is lacking.<sup>1</sup> Nevertheless, the evidence is convincing enough to warrant changing the terminology to "viral pericarditis," a step already taken by many.

For the average practitioner, establishing viral etiology in acute pericarditis is most often a process of exclusion. And exclusion is important, since non-viral entities may be responsive to specific therapy and/or may be of more serious prognostic import.

### Clinical Features

Viral pericarditis most often strikes in the third or fourth decade, but can affect any age group; sex incidence is approximately equal.

The typical victim presents as an anxious young adult with a history of recent upper respiratory infection, who is complaining of anterior chest pain, and who has malaise, low-grade fever, a slightly narrowed pulse pressure, moderate tachycardia, a pericardial friction rub with otherwise normal heart sounds, an electrocardiogram which shows elevation of the S-T segment, and a slightly elevated leukocyte count.

### Diagnosis

Given the above features, the diagnosis of *pericarditis* is not difficult to make; determining *etiology* may present problems. If one can exclude rheumatic fever, myocardial infarction, lupus erythematosus, and bacterial (tuberculous and non-tuberculous) in-

fections, a virus is very likely the culprit.

Rising serum viral antibody titers and recovery of viruses from the pharynx, stool, or urine provide circumstantial evidence. Direct culture of pericardium or pericardial fluid is more exact, but obtaining these is not ordinarily justified.

### Treatment

Barring tamponade or massive effusion, either of which requires pericardiocentesis, symptomatic treatment will suffice. In my experience,<sup>2</sup> aspirin has usually been adequate for relief of pain, but an occasional patient requires adrenal corticosteroids. For the average patient, aspirin or steroids are needed for only five to ten days. Modified bed rest should be advised until inflammation has subsided, but it is rarely necessary for more than seven to ten days.

### Prognosis

Complete recovery is the rule in most individuals. Occasionally there is a recurrence; I have followed one patient through five distinct episodes that were clinically identical (viral etiology presumed, never proven).

Whether or not constrictive pericarditis ever occurs is an unsettled issue. Clark<sup>1</sup> states that an increasing number of cases are being reported, but does not identify his sources. On the other hand, Wood<sup>3</sup> and Carmichael, *et al*<sup>4</sup> reported that none of their patients developed constriction.

It is hoped that further information in regard to the entire problem, including possible methods of prevention, will be forthcoming.

558 Medlock Road

*Bibliography on request.*

*Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.*

## "TEN COMMANDMENTS FOR THE PREVENTION OF ALCOHOLIC ADDICTION" NOW AVAILABLE

"The Ten Commandments for the Prevention of Alcoholic Addiction" is now available, free of charge, in one-page pamphlet form. Anyone interested in obtain-

ing the pamphlet may write to: Silver Hill Foundation, The Terhune Clinic, Valley Road, New Canaan, Connecticut.



## SOCIAL SECURITY FOR PHYSICIANS

John L. Moore, Jr., *Atlanta*

**B**EGINNING with the tax returns for the calendar year 1965, doctors of medicine will have to add one more schedule and pay another tax. The Social Security Act Amendments of 1965 not only adopted the Medicare provisions but also brought under the general coverage of the Social Security Act and taxes self-employed doctors of medicine. As a result, the readers of this Page can look forward to filing by April 15, 1966, a Form 1040 (basic return), Schedule B (supplemental income, etc.), Form 3468 (computation of investment credit), Schedule G (income averaging), and Schedule C-3 (computation of Social Security self-employment tax) as well as a Schedule C if the taxpayer happens to have additional business income.

Beginning with tax years of self-employed doctors of medicine ending on or after December 31, 1965, meaning for most doctors in Georgia the calendar year 1965, doctors of medicine must pay the full Social Security tax. For 1965, it is a maximum of \$259.20, if self-employment income is as much as \$4,800 for the entire year.

### Tax Going Up

For the calendar year 1966, most doctors of medicine will pay \$405.90 because the maximum self-employed earnings are \$6,600 instead of \$4,800, and the rate increases from 5.4% to 6.15%. There are further increases in the coming years until 1987, when the rate for self-employed persons will be 7.8% and the basic Social Security tax for self-employed persons earning more than the maximum covered income will be \$514.80.

It is not necessary for self-employed physicians to do anything about the new tax until the filing of his income tax return for the calendar year 1965. At that time he must complete Schedule C-3 giving his name and address and his name as shown on his Social Security card as well as his Social Security number. He then states his self-employed income which, in most cases, will be in excess of the maximum subject to tax. From the maximum subject to

tax he is allowed to deduct that amount of his income on which an employer has paid Social Security taxes and withheld such taxes from his salary. For example, if in 1965 a physician had \$1,000 of income from teaching and the educational institution had deducted Social Security taxes from the \$1,000, he may deduct \$1,000 from \$4,800 and pay the self-employed rate of 5.4% on \$3,800 rather than \$4,800. There is an advantage to the professional person having income as an employee because the self-employed tax rate is one and one-half times the withholding rate on an employee.

It is almost certain that most physicians in Georgia will have Social Security numbers by now because of the new Internal Revenue Service practice of requiring the filing of income tax returns by Social Security number. If, however, you have applied for and received a tax return number which is not a Social Security number, you should immediately apply for a Social Security card by contacting your nearest Social Security office. It takes several weeks to receive a Social Security card and you will need to have a number by the time you file your 1965 return by April 15, 1966.

### Planning Considerations

Obviously, physicians should keep in mind the need to pay an additional \$259.20 of tax next April.

More importantly, physicians should realize that they can now plan on Social Security benefits in disability and estate planning. If the self-employed physician has paid his Social Security tax for the required number of quarters at the maximum level, his primary insurance amount (the same amount as he receives upon retirement at reaching 65) will be \$168 a month. Remember that this income will be tax-free. To a man who is normally paying a 40% tax rate, it would take a capital investment of \$83,325 to develop such an income after taxes assuming a 4% rate of return.

Further, the survivors' benefits for the widow and minor children are substantial. If the deceased



physician leaves two or more minor children (up to 22 years of age if still being educated), the widow will receive \$368 a month of tax-free income. There are many variations depending on the number of children still in minority, the age of the widow, etc. If a covered person becomes disabled from engaging in any substantial gainful activity and the disability has lasted or can be expected to last for twelve months, he will receive a tax-free benefit the same as if he had become 65 and retired.

It is obvious that these increments to the disability and estate plans of medical doctors should be taken into consideration in writing insurance coverage and in reviewing such coverage. These benefits can be of particular importance to the younger professional man with a large family who finds it hard

to pay the premiums on enough insurance. Your insurance agent will be familiar with these coverages and able to help you in planning because of them.

Once covered by the Social Security scheme, physicians and their families will also have the Medicare benefits. Because of the medical profession's custom of treating other physicians and their families without fees, this may not be as important a coverage as it is to other persons. However, consideration needs to be given to the Medicare coverage to the extent physicians and their families carry health and hospital insurance.

Suite 1220  
C & S Bank Building

*Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.*

## STREAMLINING THE 1966 MAG ANNUAL SESSION

It has been noted during past years that physician attendance at the Medical Association of Georgia Annual Sessions is on the decrease. This trend is in contradiction to the steady growth of MAG membership which has risen to 3,300. A host of reasons may be cited, but the fact remains that only some 20% of the MAG membership attended the last Annual Meeting. And the question is, what's to be done about it?

After study of all factors affecting attendance, the MAG Annual Session Board presented a new "streamlined" program format for the 1966 annual meeting in Columbus, Georgia. The Executive Committee of MAG Council approved this program revision and the major changes include:

- a shortening of the overall program to start Sunday afternoon and adjourn Tuesday at noon, thereby keeping a physician away from his office practice less than two days;
- a renewed emphasis on postgraduate education

with all specialty societies having scientific section meetings on Sunday afternoon;

—allowing all specialty societies seeking to meet alone as they wish for their scientific section meeting on Sunday afternoon rather than having four or five groups meeting together;

—scheduling a combined MAG Business and House of Delegates meeting Monday morning followed by their combined meetings again on Tuesday morning;

—convening a single General Session for all members (with no conflicting meetings allowed) on a medical socio-economic subject Monday morning and a single General Scientific Session for all members Monday afternoon.

This condensed program merits your attendance, and you will receive further publicity on the entire program later this year. Let's reserve the dates of May 8-10, 1966, for this MAG Annual Session in Columbus, Georgia. A brief outline of the program is as follows:

### 1966 MAG ANNUAL SESSION FORMAT

#### SUNDAY

- 2:00 p.m.  
Scientific Sessions (8 to 10 sections meeting at once)
- 5:00 p.m.  
Business Meeting (Nominations)
- 6:00 p.m.  
Alumni Social Hours and Banquets

#### MONDAY

- 9:00 a.m.  
Joint Business and House of Delegates Meetings
- 10:30 a.m.  
MAG General Session on Medical Socio-Economics (one meeting for all)
- 12:00 noon  
GaMPAC
- 2:30 p.m.  
MAG Scientific General Session (one meeting for all)
- 2:30 p.m.  
Reference Committees
- 6:30 p.m.  
Social and President's Banquet

#### TUESDAY

- 9:00 a.m.  
Joint Business and House of Delegates Meeting
- 12:00 noon  
Adjourn



## "MENTAL HEALTH"

J. Kenneth McDonald, M.D., *Augusta*

**M**ENTAL HEALTH can be defined as not only the absence of a psychiatric disorder but also as a state of well being. Leon Saul, M.D. in his book *Emotional Maturity*, for the most part, equates Mental Health with being emotionally mature. He elaborates eight pathways of development that an individual follows in his growth towards emotional maturity. These eight pathways or areas seem to offer a reasonable approach to thinking about what constitutes Mental Health.

### The Development

The first area involves the development from a dependent infant to a relatively independent adult. The presence of excessive dependent, immature, infantile longings, need for love, attention and affection certainly appears to be a common finding in individuals with psychiatric difficulties.

The second area which is closely allied to the first, involves the development in an individual for an increasing capacity for responsibility and work. The ability to work and produce is one of the cardinal signs of Mental Health.

The third pathway involves the person working through his feelings of inferiority and thus freeing himself from the necessity of acting superior and competing excessively with others. As all children are inferior, this task is common to all.

The fourth pathway is developing standards of

behavior, ideals, or a conscience.

The fifth pathway of emotional development requires that the person develop the ability to mate and reproduce in a mature, sociably acceptable fashion. Here again, this is an important sign of health.

The development of a minimum of hostility within the individual is the sixth pathway of development. It is noted that the word minimum is used here, for certainly everyone must have the hostility with which to defend themselves in their relationship with others.

The seventh pathway is the development of a firm sense of reality, that is, knowing what the world is like, what to expect from others, etc.

The eighth area or pathway requires that an individual develop the ability to be flexible in his behavior. One of the principal signs of a neurosis in an individual is lack of flexibility in his behavior. This lack of flexibility involves many things, such as the feeling that "I must always work very hard," inability to relate to all authority figures, fear of all members of the opposite sex, etc.

Finally, Dr. Saul points out in his writings that one of the best signs of a person being mature is the ability of the person to accept some immaturity in himself.

*1445 Harper Street*

*Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.*

## EMORY MEDICAL SCHOOL'S DEPARTMENT OF PSYCHIATRY TO HOLD SECOND ANNUAL INSTITUTE ON GROUP BEHAVIOR AND GROUP LEADERSHIP

Georgia's Second Psychiatric Institute on Group Behavior and Group Leadership will be conducted by the Department of Psychiatry, Emory University School of Medicine at Callaway Gardens October 27-October 30, 1965.

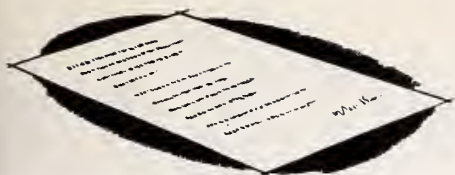
Principal speakers will be Dr. David Blau, Assistant Clinical Professor of Psychiatry in the Boston University School of Medicine, Boston, Massachusetts; Dr. Bernard C. Holland, Professor and Chairman of the Department of Psychiatry at Emory; Dr. Alfred A. Messer, Professor of Psychiatry at Emory, and Dr. Noah Langdale, President of Georgia State College, Atlanta, Georgia.

Those attending the Institute will actually participate by functioning in small groups that will hold two-hour sessions under trained leaders five times during the four-day meeting.

In these sessions the Institute member will see and sense how human emotions shape and influence group behavior. Special emphasis will be focused upon the role of the leader in everyday group behavior.

For information concerning pre-registration write or call: Georgia Institute on Group Behavior and Leadership, Att: Mrs. Louise Hanna, Department of Psychiatry, Emory University, Atlanta, Georgia 30322.





## ABSTRACTS BY GEORGIA AUTHORS

**Galletti, Pierre, M.D., Ph.D., Emory University (Department of Physiology), Atlanta, Georgia, "Laboratory Experience with 24 Hour Partial Heart-Lung Bypass," J. Surgical Research 3:97-104(March)65**

The development of blood pumping techniques for "assisted circulation" is often regarded as a natural outgrowth of extracorporeal blood circulation, but it is clear that assisted circulation is a more complex undertaking than the simple, temporary replacement of the heart and lungs required for open-heart surgery. A wide variety of potential procedures are available including venovenous oxygenation, veno-arterial pumping with oxygenation, arterio-arterial oxygenation, and arterial-counter pulsation. Devices may supplement kidney and liver as well as heart and lungs by utilizing dialysis or cross dialysis in addition to oxygenation. The main conclusion to be drawn is that all perfusion procedures have advantages and drawbacks. If one disregards the question of technical complexity and concentrates on physiological problems, he will conclude that most available techniques have potential applications in one disease or another. At this point in the development of techniques for "mechanical assistance to the failing heart," there is still a need for extensive laboratory investigation. Pilot clinical studies are justified for those who have the experience, the equipment and the hospital facilities required for such investigations. Hopefully, the use of mechanical hearts, lungs, and kidneys will open a new era in the treatment of conditions which resist conventional drug therapy and claim numerous lives.

**Anabtawi, Isam N., M.D.; Robert G. Ellison, M.D.; and Lois T. Ellison, M.D., Medical College of Georgia, Augusta, Georgia, "Pulmonary Arteriovenous Aneurysms and Fistulas," Ann. Thoracic Surg. 1:277-285 (May)65**

The embryology of these anomalies is reviewed and a classification is proposed. Variations in anatomical structure is explainable in the light of present knowledge of the pulmonary vascular development. The relationship of fistula to anomalous venous drainage is emphasized and evidence is presented in support of the proposed classification.

**Nelson, George H., Ph.D., M.D.; Frederick P. Zuspan, M.D.; and Lewis T. Mulligan, M.S., Medical College of Georgia, Augusta, Georgia, "Placental and Cord Blood Lipids: Comparison in a Set of Double Ovum Twins, a Stillborn and a Live-Born," Am. J. Obst. 91:949-952(April)65**

Separate placentas and cord bloods were obtained at delivery from a 26-year-old primigravida eclamptic patient who delivered twins. A single fetal heart beat was heard on admission which was approximately 14½ hours before delivery. The first infant was a stillborn male weighing 2,180 grams

and the second a live-born male weighing 2,280 grams. No cause for the one fetal death was apparent at delivery. Determinations of phospholipid, total and free cholesterol, triglyceride, and nonesterified fatty acids were made on the placental tissue and cord blood samples. Similarities occurred in all fractions studied except the cord blood triglyceride and nonesterified fatty acid levels. The serum of the stillborn infant contained ⅓ as much triglyceride and 2½ times as much nonesterified fatty acids as did the live-born infant. The suggestion is made that increased lipoprotein lipase activity in the cord blood may accompany intrauterine fetal deaths. The phospholipid content and total lipid content of the stillbirth placenta were higher than any values obtained in this laboratory where a total of 26 placentas of live-born infants have been analyzed.

**Floyd, Waldo E., Jr., M.D., 801 Spring Street, Macon, Georgia, "Reconstructive Procedures in Hand Injuries," South M.J. 58:686-689(June)65**

Flexion contracture of the wrist as is seen in Volkmann's contracture has been treated by a number of procedures. Most of these procedures have been based on the principle of actual or relative lengthening the distance between the origin and the insertion of the flexor muscle mass. Direct tendon lengthening and muscle sliding procedures have been utilized with excision of contracted fibrous tissue. Carpectomy and bone shortening procedures have been utilized to give relative tendon lengthening. Some 20 cases will be presented in which these various procedures were utilized. A new approach, which to my knowledge has not been previously reported, will be presented. In this technique wrist motion is preserved by partial osteotomy of the radius and excision of the distal ulna as in the Darrach procedure. The end results in this approach have been most gratifying.

**Yeh, Thomas J., M.D.; Robert G. Ellison, M.D.; and Claude-Starr Wright, M.D., Medical College of Georgia, Augusta, Georgia, "Hemolytic Anemia Due to a Ruptured Prosthetic Aortic Cusp," J. Thoracic Surg. 49:963-967(June)65**

A case of hemolytic anemia of mechanical origin due to rupture of a Bahnon Teflon aortic cusp prosthesis has been reported. The hemolysis manifested itself about a year following surgery, with the simultaneous appearance of a diastolic aortic murmur. Although initially it was thought unlikely that the ruptured cusp was the cause of hemolysis, later, by exclusion, this was concluded to be the case and the ruptured cusp was replaced with a Starr-Edwards prosthesis. The patient made an uneventful recovery and hemolytic anemia has not recurred. This case is believed to be the first reported one in which hemolytic anemia due to

a ruptured aortic prosthetic cusp has been treated successfully by this method.

**Nelson, George H., Ph.D., M.D., Medical College of Georgia, Augusta, Georgia, "Serum Nonesterified Fatty Acid Levels in Human Pregnancy as Determined by Various Titration Procedures," Am. J. Obst. 92:202-206(May)65**

There has been recent controversy concerning the serum levels of nonesterified fatty acids (NEFA) during late pregnancy. Different titration procedures are used in different laboratories to measure serum NEFA and it has been claimed that the wide variation of results reported in the literature is due to a difference in titration procedure used. Because of the importance of this measurement in the study of carbohydrate and lipid metabolism this study was designed to study serum NEFA levels in nonpregnant patients, pregnant patients from 36 to 40 weeks gestation, and patients at delivery. These measurements were determined by a variety of titration procedures in an effort to see if a variation in titration procedure was responsible for the large variation of results in the literature. It was found that patients at delivery have higher NEFA levels than patients near term, while those near term have higher NEFA levels than nonpregnant females. The following variables have been shown to affect the value of NEFA obtained: A. Ratio of heptane and water added to serum and extraction mixture, B. Single extraction technique versus double extraction technique versus acid wash technique, and C. Nature of the indicator used for titration. While the above variables do affect the value obtained, their effect is rather small and these variables do not seem likely to explain the marked variability in NEFA levels in late pregnancy which appear in the literature.

**Whaley, William H., A.B.; Frederick P. Zuspan, M.D.; and George H. Nelson, Ph.D., M.D., Medical College of Georgia, Augusta, Georgia, "Glucose and Nonesterified Fatty Acid Levels in Maternal and Cord Plasma," Am. J. Obst. 92:264-266(May 15)65**

Glucose and NEFA values were determined in simultaneous maternal and cord-blood plasma samples obtained from 44 normal patients at the time of delivery. Maternal NEFA and glucose levels (average 881.8 mEq/L and 92.8 mg/100 ml) were consistently higher than newborn levels (average 536.0 mEq/L and 71.9 mg/100 ml). The maternal: newborn NEFA ratio was 1.7:1, and the maternal: newborn glucose ratio was 1.3:1. The difference between maternal and fetal glucose levels may reflect placental metabolism.

The glucose: NEFA ratios were significantly different in the mother and newborn. This finding suggests that the interrelationships of these substances in the two circulations are not identical.



# THE ASSOCIATION



## DEATHS

LORIN VAN STRICKLAND, 84, of Cobbtown, died June 19, 1965, in the Oglethorpe Hospital in Savannah after several weeks illness. He attended and was graduated from the Bulloch County Schools and the Medical College of Georgia in Augusta.

Dr. Strickland had been practicing medicine since 1908 and was a member of the First District Medical Society and the American Medical Association. He was prison doctor at the Georgia State Prison in Reidsville for 20 years. For 19 years he served as a member and chairman of the Tattnall County Board of Education. He was chairman of the Tattnall County Democratic Executive Committee. Recently the Roger Wood Masonic Lodge of Cobbtown presented Dr. Strickland with a fifty year membership pin. He was a member of the Cobbtown Missionary Baptist Church, was mayor of Cobbtown for several years and was a member of the staff of Governor Carl Sanders and a member of the staff of former Governors Ed Rivers and Ernest Vandiver.

He is survived by his wife, Mrs. Marie Brinson Strickland of Cobbtown; two sons, L. Van Strickland, Jr., Statesboro and John Albert Strickland of Cobbtown; four grandchildren; three brothers, John M. Strickland, Register; Jim H. Strickland, Register; and William W. Strickland, Statesboro; two sisters, Mrs. Mary DeLoach of Savannah and Mrs. Minnie McCorkle of Nevils.

## SOCIETIES

DEKALB COUNTY MEDICAL SOCIETY held its

July meeting at Decatur. Guest speaker was Judge Curtis V. Tilman whose topic was "Group Therapy Home 'Keystone.'"

## PERSONALS

### First District

ED STRICKLAND, JR. began his practice of surgery in Swainsboro July 12, 1965. He is a native of Calhoun.

### Fifth District

CHARLES M. HUGULEY, Atlanta, attended a meeting of the Task Force for Chronic Leukemias and Myeloma of the National Cancer Institute in New York City on June 17 and was installed as chairman of the task force for the coming year. He also attended the AMA's national convention in New York City where he participated in a special symposium on adverse drug reactions.

BERKLEY S. EICHEL, who has been a resident in ear, nose and throat in the Mayo Foundation in Rochester, Minnesota, has left that city and will be located in Atlanta.

### Seventh District

MARTIN I. GOLDSTEIN has announced the opening of his office for the practice of dermatology at 145 West Spring Street in Smyrna.

### Ninth District

CHARLES LITTLE, orthopedic surgeon, has opened offices in Gainesville.

## MAG'S RESPONSIBILITY FOR THE FORWARD LOOK

The Medical Association of Georgia has a vital responsibility to its membership in keeping the profession well informed about medical and socio-economic developments in the changing times. To fulfill this objective of a state medical association, important meetings on current subjects of prime interest to the profession are being scheduled.

The MAG Mental Health Subcommittee will hold a meeting for county medical society leaders to discuss and explain the ramifications of Georgia's Mental Health program as it involves the proposed Community Mental Health Programs to be developed in certain areas of the state.

On another subject of concern, a special MAG Committee on Areawide Hospital Planning will call a meeting for the leadership of metropolitan and semi-metropolitan county medical societies to provide information on all aspects of Areawide Hospital Planning Councils and agencies.

In yet another type of medical activity, an MAG ad hoc Committee on Medical Ethics is developing a program on the Principles of Medical Ethics—the policies and practice. This subject will be the keynote of the

Association's annual County Medical Society Leadership Conference.

As dictated by the 1965 MAG House of Delegates, a "negotiating committee" composed of representatives of all specialty societies will convene in September. This committee has the responsibility for negotiating "fee schedules" with third parties in behalf of the Association.

The MAG School Child Health Subcommittee is again sponsoring a meeting for physicians on the Medical Aspects of Sports. The Association Rural Health Subcommittee is engaged in planning a statewide Rural Health Conference. And the MAG Annual Session Board has instituted many new innovations for the Association's 1966 Annual Session in Columbus, Georgia.

Still another activity includes the MAG Board of Medical Education plans for the Second Annual Conference on Medical Education for practicing physicians and medical school educators scheduled in February of 1966. And the MAG Board of Special Activities is now investigating the statewide educational television network facilities to ascertain its possible use in the field of both professional and public medical education.



# 19th CLINICAL CONVENTION OF THE AMA



## PHILADELPHIA, PA.—NOV. 28-DEC 1, 1965

Plan to attend the world's most comprehensive four-day postgraduate course in recent developments in medical science, and participate in the observance of the founding of the first medical college established in this country—the Medical School of the University of Pennsylvania.

This postgraduate refresher course, conducted by the nation's outstanding medical authorities, will be presented for you in historical Philadelphia. Philadelphia has many luxurious hotels and colorful restaurants. Mail the enclosed registration and room reservations coupons now!

**TWO POSTGRADUATE COURSES:** Gynecology and Obstetrics; and Cardiovascular Therapeutics (each to be presented in 3 half-day sessions) **BREAKFAST ROUND-TABLE DISCUSSIONS:** Gynecologic Difficulties in the Adolescent • Early Management of Traffic Accident Patients • Common but Worrisome Pediatric Problems • The Nature of Chronic Bronchitis and Pulmonary Emphysema • Prevention of Long Term Illness: A Practical Approach • Clinical Uses of Electroencephalography

**SCIENTIFIC SESSIONS:** Ulcerative Colitis • Pediatrics • Chemotherapy of Cancer • Preventive Surgery in Cancer • Bacterial Infections • Ultraviolet Irradiation in Medicine • Genetics • Current Status of Drug Therapy in Rheumatology • Psychiatry • Urology • Gastrointestinal Surgery • Cardiovascular Surgery • Current Concepts of Shock • Computers in Medicine • Pain in the Back • Orthopedics • Common Otology Problems • Eye Problems and the Non-Ophthalmologist • CLOSED CIRCUIT COLOR TELEVISION • MOTION PICTURE PREMIERES • Hundreds of SCIENTIFIC AND INDUSTRIAL EXHIBITS

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA October 25



The ideal way to distribute vital and timely health information to your patients is with the AMA's New Pamphlet Rack Program—8 selected pamphlets and a decorative, handy display rack.

You receive 200 pamphlets (25 each of 8 selected pamphlets) that are scientifically sound, easy-to-understand and written on a wide variety of subjects. They supplement your counsel to patients by covering pertinent and timely topics . . . heart disease, cancer, smoking, acne and other skin problems, first aid, medicines, weight reduction, and health examinations.

The handsome NEW metal pamphlet rack has a rich walnut grain finish that will enhance the decor of

your office or reception area. It is designed to help you display pamphlets neatly and attractively. Measuring 19 $\frac{3}{4}$ " x 5" x 9 $\frac{3}{4}$ ", the pamphlet rack can be placed on a table top or conveniently hung on the wall.

With your order you will also receive a complete catalog describing some 80 other AMA health education pamphlets from which refills may be chosen at any time.

To order your 200 pamphlets and display rack, complete the coupon below. Mail it with your remittance of \$6.95 for each Program to the AMERICAN MEDICAL ASSOCIATION, 535 North Dearborn Street, Chicago, Illinois 60610.

## NEW PAMPHLET RACK PROGRAM

**200 PAMPHLETS**

and a handsome display rack **\$6.95**  
... now only



**I enclose \$** to cover the cost of . . . PAMPHLET RACK PROGRAM(S). I will receive one rack and 25 each of 8 selected pamphlets for every PAMPHLET RACK PROGRAM I order.

**Sorry, only  
paid orders  
can be  
accepted.**

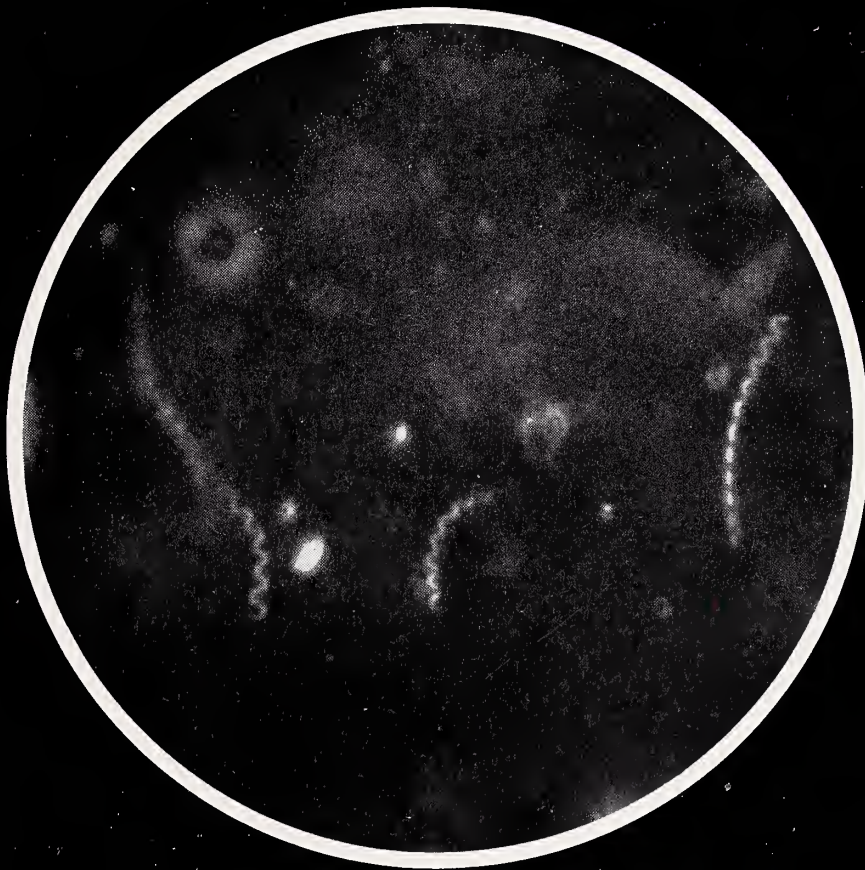
NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP \_\_\_\_\_ 8-16

**Mail to: AMERICAN MEDICAL ASSOCIATION/  
535 N. Dearborn St./Chicago, Ill. 60610**



**JOURNAL**  
OF THE **MEDICAL**  
ASSOCIATION

OCTOBER / 1965  
*Georgia*



U.C. MEDICAL CENTER LIBRARY

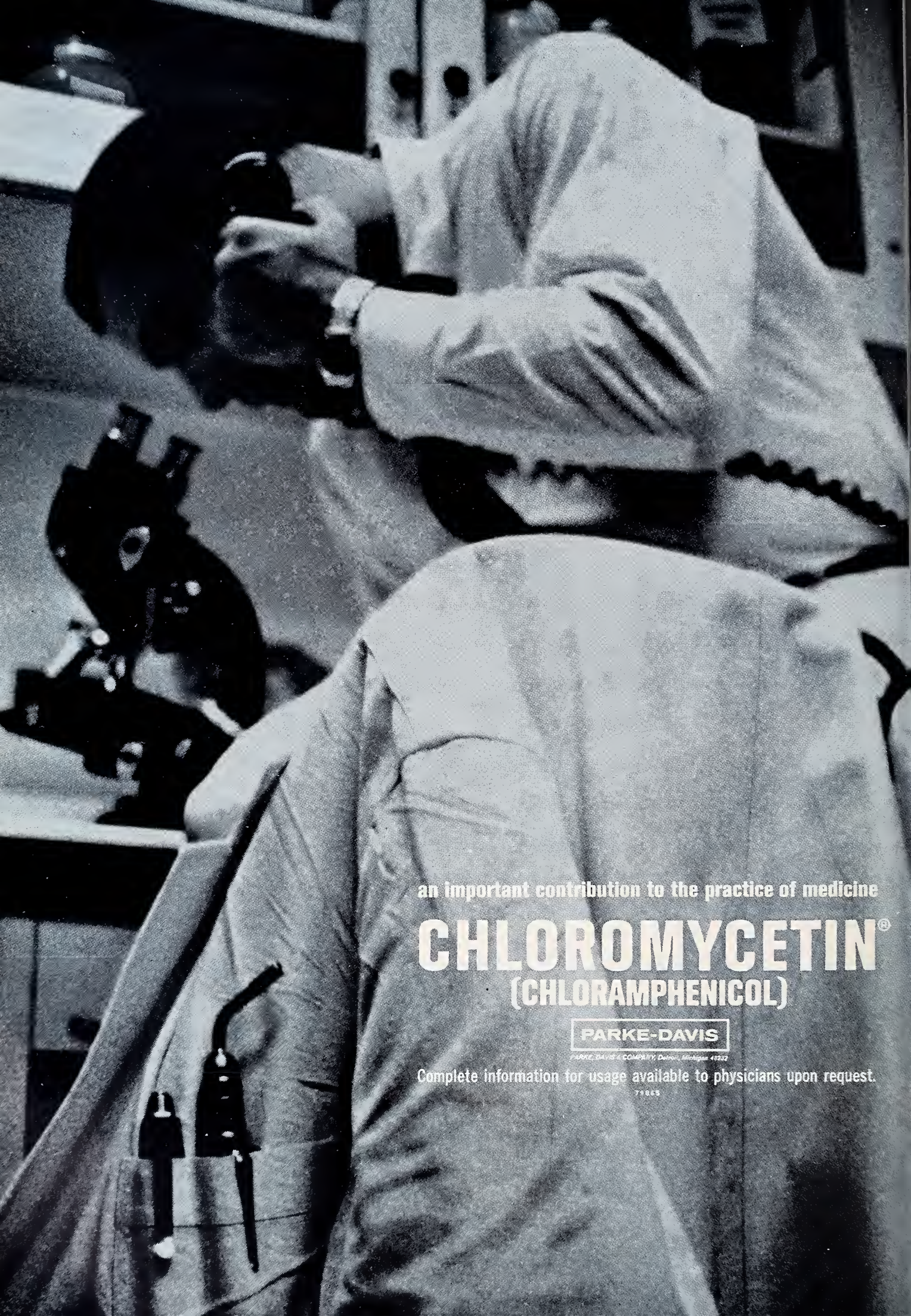
JAN 10 1966

San Francisco 22,

**Venereal Disease in Georgia**

See page 337





an important contribution to the practice of medicine

# CHLOROMYCETIN<sup>®</sup>

(CHLORAMPHENICOL)

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232

Complete information for usage available to physicians upon request.

71063



JOURNAL  
OF THE MEDICAL  
ASSOCIATION

Georgía

EDITOR

Edgar Woody, Jr., M.D.

MANAGING EDITOR

Miss Merrillie M. Davis

STAFF

Thelma V. Franklin, *Business*

CONTRIBUTING EDITORS

Herbert S. Alden, M.D.; Pres-  
ton D. Ellington, M.D.; Thomas  
Findley, M.D.; J. Willis Hurst,  
M.D.; Charles S. Jones, M.D.;  
Arthur M. Knight, Jr., M.D.;  
Arthur J. Merrill, M.D.; Lester  
Rumble, Jr., M.D.; Peter L.  
Scardino, M.D.; Patrick C.  
Shea, Jr., M.D.; Robert H.  
Vaughan, M.D.

PUBLICATIONS COMMITTEE

George H. Alexander, M.D.;  
Walter E. Brown, M.D.; J. G.  
McDaniel, M.D.; Henry S. Jen-  
nings, M.D.; Charles R. An-  
drews, Jr., M.D.; John T. Maul-  
din, M.D.; John S. Atwater,  
M.D.; F. G. Eldridge, M.D.

THE ASSOCIATION

George H. Alexander, M.D.,  
*Pres.*; Walter E. Brown, M.D.,  
*Pres.-Elect*; J. G. McDaniel,  
M.D., *Past Pres.*; Charles R.  
Andrews, Jr., M.D., *Chm. of*  
*Council*; John T. Mauldin, M.D.,  
*Sec.*; John S. Atwater, M.D.,  
*Treas.*; J. Frank Walker, M.D.,  
*Speaker*; Mr. Milton D. Krueger,  
*Exec. Sec.*; Mr. James M. Moffett,  
*Asst. Exec. Sec.*; Mrs. Catherine  
Wooten, *Asst. Exec. Sec.*

THE JOURNAL OF THE  
MEDICAL ASSOCIATION OF  
GEORGIA, established 1911.  
Owned, edited and copyrighted,  
1965, by the Medical Association  
of Georgia, 938 Peachtree  
Street, N.E., Atlanta, Georgia  
30309. Published monthly under  
the direction of the Council of  
the Association. Subscription  
rate: \$7 per year; \$1 per single  
copy. Second-class postage paid  
at Fulton, Missouri.

Contents

Scientific Articles

ADJUNCT PROPHYLACTIC PROCEDURES WITH RADICAL MASTECTOMY TO DECREASE RECURRENT BREAST CANCER Edgar D. Grady, M.D. and Thomas R. Nolan, M.D.	321
CATATONIA AS A CAUSE OF FEVER OF UNDETERMINED ORIGIN Joseph G. Bohorfoush, M.D.; James B. Craig, M.D., and H. Scott Patterson, M.D.	324
EXPERIENCE WITH CARCINOMA OF THE COLON IN A COMMUNITY HOSPITAL Vance Watt, M.D.	326
DIAGNOSIS AND TREATMENT OF CONVULSIVE DISORDERS IN CHILDREN Richard J. Allen, M.D.	330

Editorials

RECENT TRENDS IN VENEREAL DISEASE RATES	337
THE EFFECTS OF HEAT UPON THE HUMAN BODY	338

Features		The Association	
President's Letter	340	Deaths	345
Heart Page	341	Personals	345
Legal Page	343	Advertising Index	48A
		Calendar	342

Contents Page Blurbs

Photograph courtesy of the Georgia Department of Public Health. Design by Noel Smith, Atlanta.



**DECASPRAY®** brings cooling relief to burning, itching, and inflamed skin at a touch. Each can of **DECASPRAY**—held upright, upside down, or at any angle—can be used 133 times (1-second sprays) to control a variety of allergic and inflammatory skin disorders, and help prevent infection... to dry moist, oozing lesions.

The latest touch in cool topical steroid-antibiotic therapy is **DECASPRAY**.... Each application leaves a uniform film that is odorless, colorless, stainless, and invisible. And, because dermatoses are sprayed—not handled—risk of spreading is lessened.

**cooling spray...**

**SUPPLIED:** In 90-Gm. seamless, pressurized cans, containing 10 mg. dexamethasone 21-phosphate and 50 mg. of neomycin sulfate (equivalent to 35 mg. neomycin base).

**ALSO AVAILABLE:** **DECADRON®** Phosphate Topical Cream in 15-Gm. and 30-Gm. tubes. Each gram contains 1 mg. dexamethasone 21-phosphate as disodium salt.

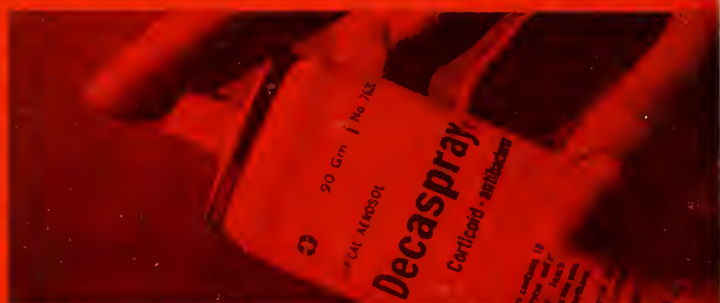
**NeoDECADRON®** Topical Cream in 15-Gm. and 30-Gm. tubes. Each gram contains 1 mg. dexamethasone 21-phosphate as disodium salt and 5 mg. neomycin sulfate (equivalent to 3.5 mg. neomycin base).

**INDICATIONS:** Dermatoses responsive to topical aerosol steroid-antibiotic therapy.

**SIDE EFFECTS, PRECAUTIONS, AND CONTRAINDICATIONS:** Do not use in presence of tuberculosis of skin, chickenpox, herpes simplex. Never spray into eyes or nose. Discontinue if infection does not respond promptly or sensitivity occurs.

Before prescribing or administering, read product circular with package or available on request.

**MERCK SHARP & DOHME** | where today's therapy is tomorrow's therapy  
Division of Merck & Co., Inc., West Point, Pa.



**immediate relief for itching and burning skin**





# ADJUNCT PROPHYLACTIC PROCEDURES WITH RADICAL MASTECTOMY TO DECREASE RECURRENT BREAST CANCER

Edgar D. Grady, M.D. and  
Thomas R. Nolan, M.D., *Atlanta*

■ No serious complications have  
been encountered in six patients.

**I**T is proposed that a concerted effort be made to utilize all beneficial available procedures to decrease recurrence of operated breast cancer. By setting up a description of the disease and of each patient for classification and by having a long term patient follow-up, the value of such grouped adjunct procedures can be assayed. The patients will at the same time benefit.

The following adjunct prophylactic procedures are suggested:

- (1) Wound irrigation with nitrogen mustard.
- (2) Intravenous Thio-TEPA during and after surgery.
- (3) Bilateral oophorectomy in pre-menopausal and up to four years post-menopausal patients.
- (4) Supraclavicular and mediastinal deep cobalt radiation therapy.

The authors have used such adjuncts with radical mastectomy in six patients. The first three were in 1960. There was no complication in any of the six patients, other than some moderate increase in serous wound drainage. All remain free of recurrent breast cancer.

There is much information available to support each of the above concepts independently. There follow excerpts of some of the many scientific reports considered pertinent to support the concept of using these adjuncts together.

## General Facts Related to Long Term Survival and Local Recurrence

Shimkin,<sup>1</sup> in a general survey of many reports of breast cancer treated by many different ways, has recently summarized crude five year survival rates 47% to 49% between 1941 and 1956. A Canadian report by Watson<sup>2</sup> described 52% five year survival rate of 1,055 patients treated with radical mastectomy and post-operative radiation.

A survey by McDonald, et al.<sup>3</sup> of different reports of local wound recurrence in various institutions gave the following incidence:

Cleveland Clinic 14.2% of 203 cases  
Massachusetts General Hospital 11% of 236 cases  
Presbyterian Hospital (NYC) 10.5% of 495 cases  
Roosevelt Hospital (NYC) 10.8% of 238 cases

Demeree<sup>4</sup> reported 17 to 33% local recurrences in various institutions.

Vermund and Kling<sup>5</sup> described 39% of 364 cases of operated breast cancer having recurrences in the operative area in five years.

## Facts Related to Wound Irrigation to Prevent Local Recurrence of Cancer

Again, McDonald<sup>3</sup> showed that nitrogen mustard and sodium hypochlorite are both effective agents to

prevent cancers growing from cells implanted into wounds. Experimental irrigation of rat wound pouches inoculated with Walker 256 cancer cells gave 90% to 100% takes when saline, water, or heparin solution was used. Sodium hypochlorite 0.5% irrigation gave eight takes in 56 pouches. When 2 mg.% nitrogen mustard was used, four tumors grew in 84 wounds. There were four takes in 54 rats irrigated with 1 mg.% nitrogen mustard.

Thomas<sup>6</sup> described many facets of wound irrigation to prevent cancer. His studies showed that oxidizing agents (chlorpactin-XCB and Dakins) and the protein precipitating agent formalin were less effective than nitrogen mustard. Anti-metabolites like 5-Fluorouracil and slow acting alkylating agents that require breakage of secondary linkage to become active were also found to be relatively of little benefit for topical application. Nitrogen mustard, which has a more immediate and direct action, was found to be highly tumoricidal. In 14 patients observed two years after wound irrigation with nitrogen mustard following radical mastectomy, seven of whom had axillary nodes, no local recurrence developed. Inch and McCredie,<sup>7</sup> after observing their animals over 100 days found that chlorpactin-XCB 0.5 grams per 100 ml of saline had no effect on tumor growths, but 1 mg of nitrogen mustard per 100 ml gave significant reduction in tumor growth.

### Adjunct Thio-TEPA With Radical Mastectomy

Noer<sup>8</sup> has collected the preliminary results of adjunct Thio-TEPA for the National Institute of Health national study and reports that, using 0.8 mg. per kg. the results as of November, 1962 showed that the treated group with positive axillary nodes had 28% less incidence of recurrence and metastases. A 12% advantage was demonstrated in patients with negative nodes.

### The Effect of Prophylactic Castration to Delay Recurrent Breast Cancer

Nicolson and Grady<sup>9</sup> found that nine of ten patients who had prophylactic oophorectomy at Steiner Clinic in Atlanta and were followed for five years, had survived without recurrence—the tenth had been lost to follow-up.

Horseley and Horseley<sup>10</sup> reported 68 cases followed for five years after adjunct surgical castration with the following five year survival:

Without positive nodes—31 of 34 (91%)  
With positive nodes—17 of 34 (50%)  
Total—48 of 68 was 71%

## The Fact That Supraclavicular and Mediastinal Disease May Need Treating, Whether the Primary Indicated This by Its Location and Whether or Not Such Disease Can Be Found Initially

Anderson, et al.<sup>11</sup> in a series of 51 patients with breast cancer and axillary metastases who also had their supraclavicular areas dissected without palpable supraclavicular disease, found 17 patients had microscopic cancer in the neck.

Handley, et al.<sup>12</sup> found that in patients with operable cancer and with axillary node metastases, internal mammary nodes were involved in 27 of 35 patients when the primary tumor was in the medial half or subareolar areas of breast and in two of 35 when tumors were in the lateral one-half. These facts were confirmed by Margottini<sup>13</sup> and Urban.<sup>14</sup>

### Radiation Can Be Effective to Eradicate Metastatic Breast Cancer

Guttman<sup>15</sup> irradiated 30 patients with positive mediastinal nodes, biopsied only. Sixteen of these survived five years after therapy with radiation only. In two of these that subsequently came to autopsy, no cancer was found in the regional nodes.

### Proposed Protocol for Prophylactic Adjuncts to Radical Mastectomy for Breast Cancer

#### 1. Thio-TEPA

A. During surgery (begun as soon as frozen section report is called positive, or at time of first incision, if pre-operative biopsy has been called positive) give intravenously 0.4 mg. per kg. Thio-TEPA dissolved in 1000 cc 5% glucose in distilled water.

B. First post-operative day give an intravenous dose of 0.2 mg. per kg. Thio-TEPA, dissolved in 1,000 cc 5% glucose in distilled water.

C. Second post-operative day give another dose of 0.2 mg. per kg. Thio-TEPA as in "B".

#### 2. Wound Irrigation

Dissolve 10 mg. nitrogen mustard in 500 cc normal saline. Irrigate wound for 4 minutes prior to closure. Suck and mop dry with a saline soaked laparotomy pad. Use suction drainage post-operatively for a little longer than usual. Expect a little more drainage than usual.

#### 3. Prophylactic Oophorectomy

If patient has menstruated in preceding 48 months, or if a maturation index vaginal wall smear shows estrogenic activity, do surgical oophorectomy, if feasible. If not appropriate to do surgical oophorectomy, and if estrogen function persists, do radiation castration.

#### 4. Post-Operative Radiation Therapy

Supraclavicular and mediastinal cobalt radiation therapy to be scheduled as an out-patient when pa-



tient has recovered from surgery sufficiently, usually two to three weeks post surgery. The ipsilateral supraclavicular area is treated by using a single anterior field extending from the mid-suprasternal notch laterally to the end of the clavicle. The height of the area will include the base of the neck and the supraclavicular regions. The internal mammary nodes will be treated by a single anterior field of 8 x 9 cm wide, so as to include both groups of nodes down through the fourth intercostal spaces.

The treatment schedule will be designed to deliver a calculated tissue dose of 4,000 rads in a period of three to four weeks.

### Comment

The aim is to do more to obtain an increase in control of breast cancer. The claim is that the morbidity is not significantly increased by these adjuncts. Specifically:

(1) Wound irrigation with nitrogen mustard has been used by the authors in other wounds like neck dissections, and in no case has it caused any problem other than the need for attention to evacuate a moderate increase in drainage.

(2) In no case has there been any toxicity from the prescribed dose of Thio-TEPA, even when the wound was irrigated with nitrogen mustard, another alkylating agent.

(3) Oophorectomy must, of course, be considered separately along with the wishes of the patient and her husband. Though childbearing is not recommended after a breast cancer, everyone is entitled to make his own decision for any such calculated risk. Whether there are positive axillary nodes, whether the lesion is medial or lateral, how long it has been present, and the cellular pattern of the primary lesion will each play a part in the surgeon's decision as to whether the ovaries should be removed.

There would naturally be some menopausal symptoms after oophorectomy. Estrogen replacement would defeat the purpose of the oophorectomy. The anabolic hormones, however, have offered a reasonable substitute for the hormone deficiency. The anabolic dose can be regulated to give no masculinizing effect, but to give a sense of energetic well-being. Sexual interest and function are more than well maintained.

The authors have had the experience of treating 17 cases of metastatic breast cancer, which were referred from other physicians. All patients had oophorectomy if ovarian function was present, and all received combinations of chemotherapy and anabolic agents. In 16 of the 17 there was control of the disease for some significant period; in over half of them the control was indefinite, up to four years. This experience of controlling breast cancer with hormones and chemotherapy has confirmed the impres-

sion that patients without ovaries can still have a good functioning normal life. We do not have to wait until metastasis develops to do the oophorectomy, because of the threat of an "empty" life without ovaries.

(4) It is important for the post-operative radiation to be given through the ports approximately as described to prevent pulmonary fibrosis. The dose described is an adequate "prophylactic" dose—to eradicate small foci that have not yet shown themselves. Only if there were larger tumor masses would a larger dose be needed.

Finally, our aim is for a higher rate of control, which is why we are suggesting that *more* should be done. We are not satisfied with a 50 or 60 or even 65% survival rate. The reason that the recent enthusiasm for simple mastectomy and radiation for breast cancer has received any acceptance at all is that the advocates of this simplified approach can get a 50% five year survival. *WHO IS GOING TO BE SATISFIED WITH THIS?*

1938 Peachtree Street, N.E.

### BIBLIOGRAPHY

1. Shimkin, M. B.: Cancer of the Breast; *J.A.M.A.* 183:146, Feb. 2, 1964.
2. Watson, T. A.: Treatment of Breast Cancer: Comparison of Results of Simple Mastectomy and Radiation Therapy With Results of Radical Mastectomy and Radiation Therapy; *Lancet* 1:1191, 1959.
3. McDonald, G. O.; Gines, S. M., and Cole, W. H.: Wound Irrigation in Cancer Surgery; *Arch. Surg.* 80:920, June 1960.
4. Demeree, E. W.: Local Recurrence Following Surgery for Cancer of the Breast; *Ann. Surg.* 134:863, 1951.
5. Vermund, H., and Kline, J. C.: *Am. J. of Surg.* 106:430, Sept. 1963.
6. Thomas, C. S., Jr.: Tumor Cell Contamination of the Surgical Wound: Experimental and Clinical Observations; *Ann. Surg.* 153:697, 1961.
7. Inch, W. R., and McCredie, J. A.: Effect of Wound Irrigation With Nitrogen Mustard or Chlorpactin-XCB on Local Recurrences of Rat and Mouse Tumors; *Cancer* 16:599, May 1963.
8. Noer, R. J.: Adjuvant Chemotherapy Thio-TEPA With Radical Mastectomy in Treatment of Breast Cancer; *Am. J. Surg.* 106:405, Sept. 1963.
9. Nicolson, W. P., and Grady, E. D.: Carcinoma of the Breast; *Ann. Surg.* 127:992, 1948.
10. Horsley, J. S., and Horsley, G. W.: Twenty Years Experience With Prophylactic Oophorectomy in the Treatment of Carcinoma of the Breast; *Ann. Surg.* 155:935, June 1962.
11. Andreasson, M., Dahl-Iverson, and Sorenson, B.: Extended Exeresis of the Region Lymph Nodes at Operation for Carcinoma of the Breast and the Results of a 5 year Follow-up of the First 98 Cases With Removal of the Axillary as Well as the Supraclavicular Glands; *Acta Chir. Scandinav.*, 107:206, 1954.
12. Handley, R. S., and Thackray, A. C.: Invasion of Internal Mammary Lymph Nodes in Carcinoma of the Breast; *Brit. Med. Jour.* 1:61, 1954.
13. Margottini, M.: Arguments in Favor of Superradical Operations for Carcinoma of the Breast; *Acta Unio Internat. Conta Cancrum*, 15:1037, 1959.
14. Urban, J. A.: Clinical Experience and Results of Excision of the Internal Mammary Lymph Node Chain in Primary Operable Breast Cancer; *Cancer* 12:14, 1959.
15. Guttman, R. J.: Survival and Results After Two Million Volt Irradiation in the Therapy of Primary Operable Cancer of the Breast With Proved Positive Internal Mammary and/or High Axillary Nodes; *Cancer* 15:383, 1962.
16. Grady, E. D., and Nolan, T. R.: Treatment of Metastatic Breast Cancer by Chemotherapy and Hormones; *Bull. Fulton Co. Med. Soc.* 28:23, July, 1964.

# CATATONIA AS A CAUSE OF FEVER OF UNDETERMINED ORIGIN

Joseph G. Bohorfoush, M.D.

James B. Craig, M.D.

H. Scott Patterson, M.D., *Milledgeville*

- Dramatic reduction of fever  
is noted following administration  
of trifluoperazine.

ON THE MEDICAL SERVICE of our hospital five to six times a year, we see associated with catatonia, a syndrome consisting of continued hyperpyrexia, tachycardia, hyperpnea and a normal or only slightly elevated leucocyte count. There is immediate and complete remission of these symptoms with appropriate treatment of the catatonia. These patients are usually admitted to the Medical Service with a preliminary diagnosis of pneumonia. The roentgenogram is negative and large doses of antibiotics fail to ameliorate the symptoms. A review of over 50 texts of medicine, psychiatry and systems of diagnoses failed to mention catatonia as the cause of hyperpyrexia without leucocytosis. We are unaware of any reference to this syndrome in the medical literature.

## Syndrome Frequently Seen

The first case of this syndrome recognized on the Medical Service of this Hospital was a 65-year-old comatose, rigid, white male whose only other finding was a questionable Babinski sign. His temperature ranged to 105°F., pulse 140 with normal leucocyte count. Roentgenograms, febrile agglutinins, blood culture, urine analysis and culture failed to reveal any infection. The spinal fluid was normal in all respects. He failed to respond to any antibiotics. Initially, it was felt that this patient was suffering some type of viral encephalitis. Seven days after admission, it was suggested by (JBC) that this was a syndrome frequently seen on the psychiatric wards and that it would respond to appropriate treatment for the cata-

tonia. He was treated with trifluoperazine\* 5 mg., P.O., q.i.d., and within 24 hours all symptoms had disappeared. In the past three years, in addition to the many cases seen on the Psychiatric Service, 15 cases have been diagnosed and successfully treated on the Medical Service.

A typical case follows: Four days after admission to the Psychiatric Division of the Hospital, a 25-year-old Negro female was admitted to the Psychiatric Infirmary because of fever. After two days of treatment with penicillin, streptomycin and thorazine, she was transferred to the Medical Service, six weeks after her first successful pregnancy. Following a difficult delivery by a competent obstetrician, "she did not do well," continued to have a vaginal discharge and "was not right in the head." She had had a fever for several weeks prior to her admission to this hospital and had been seen in consultation by a second obstetrician, a surgeon and an internist. During this time she had been confined in a psychiatric unit in a general hospital. Her past history revealed an emotional disturbance for which she was treated for the two years preceding her present difficulties. She had had several miscarriages.

While in the infirmary her temperature was 102°F.; WBC 8,000; 70% PMN; 28% lymphs; 1 monocyte and 1 basophile. Physical examination revealed secretions in the nostrils with moist rales in the mid area of the right lung. No roentgenogram of her chest was made.

After admission to the Medical Service, a physical examination revealed an obese, 200 pounds, stuporous and unresponsive Negro female. Her temperature

\* Stelazine.



was 104.6°F.; respiration 36/min; pulse 160/min and blood pressure 130/85. Food was found in her mouth although her last intake was three hours previously. She lay supine, exhibiting *flexibilitas cerea* and reacting only to very painful stimuli. There was a polyp in her right nostril. A grade 2 systolic murmur was heard at the apex. The remainder of the examination was not significant. Laboratory studies on admission to the Medical Service were WBC 10,000; PMN 85%; Hb. 13.5; Hct. 42; Blood Glucose 124; BUN 20; VDRL non reactive; total serum bilirubin 0.6 mgm%; CO<sub>2</sub> content 23 mEq; Cl 113 mEq; Na 155 mEq and K 3 mEq. Urinalysis normal. Except for the tachycardia the ECG was normal. A chest film revealed no lung pathology. Cultures from the throat and of urine and blood were negative for pathogenic organisms. ASO titer and febrile agglutinin studies were negative.

After cultures were taken, penicillin and chloromycetin intravenously were started. Intravenous fluids were given in sufficient quantity to prevent dehydration. She received aspirin and was sponged with tepid water. Her temperature was reduced to 102°F., on the first hospital day. On the second day her temperature rose to 103.6°F., notwithstanding the use of sponges and aspirin. At this time the gynecologist could find no demonstrable evidence of pelvic pathology. That the hyperpyrexia might be a function of the catatonia was now considered. Antibiotic therapy was discontinued and trifluoperazine, 5 mg. q.i.d., by mouth was started at 5:00 p.m. on the second day when her temperature was 102.6°F. At 5:00 a.m. the next morning, twelve hours subsequent to the initiation of trifluoperazine therapy, the patient got out of bed, drank milk, walked around the room and began to mumble. On this day her temperature fell to 99°F. rectally and remained normal; her pulse remitted to 80/min and her respirations to 20/min. She was discharged from the Medical Service to the Psychiatric Service on the eighth hospital day. To rule out the possibility of drug fever, on the sixth hos-

pital day, she was given large doses of all drugs that she had previously received without any elevation of temperature.

Our last case with this syndrome responded to adequate doses of trifluoperazine. The dose of the drug was immediately reduced to 2 mg. b.i.d. and on this inadequate intake he relapsed within 48 hrs. Within 12 hrs., after restoration of adequate dosage (5 mg., P.O. q.i.d.), there was a second complete remission.

### Comment

The sameness of these cases would make a report of several a monotonous repetition. They are usually admitted to the Medical Service with a diagnosis of pneumonia. They have hyperpyrexia, tachycardia, hyperpnea, with a normal, or only slightly elevated leucocyte count. A few rales over the lungs are usually reported. The roentgenograms of the chest are normal and the patient fails to respond to antibiotics. Laboratory studies for pathogenic organisms are negative. These symptoms cannot be attributed to dehydration because all of our cases have received an adequate amount of fluid intravenously. The uniform responses within 12-24 hrs. are as dramatic as one would expect from penicillin in an infection due to a sensitive organism. The functional physiology in the brain is markedly disturbed in catatonia and there is no reason to except the temperature regulating area. We feel that the hyperpyrexia is a manifestation of the catatonia. The treatment of choice on the psychiatric service is shock. The response to this form of treatment is dramatic and occurs within 12-24 hours. On the Medical Service trifluoperazine is used with apparently equally good results.

### Summary

A syndrome of hyperpyrexia, tachycardia, hyperpnea associated with a normal or almost normal leucocyte count seen in catatonia is reported. A typical case has been described in detail.

*Milledgeville State Hospital*

## SMITH, KLINE & FRENCH SPEECH-MAKERS LOG 10,000 TALKS TELLING STORY OF PHARMACEUTICAL INDUSTRY

Speech makers for Smith Kline & French Laboratories passed a significant milestone recently with delivery of the 10,000th talk in the company's campaign to tell the story of the pharmaceutical industry to the American people.

In Georgia, Smith Kline & French speakers have given 265 talks before audiences totaling more than 11,200 persons.

About half of these speeches were arranged through pharmacists and physicians.

Logging more than 4,000 hours on platforms in 48 states and the District of Columbia during the past six

years, SK&F's trained speakers have addressed more than 400,000 persons face-to-face and reached several million others through radio and television.

Smith Kline & French launched its Speakers Bureau program in 1959 in the belief that one of the best ways to tell the story of the drug industry's role as a member of the health team is to talk to people directly.

All 405 SK&F fieldmen and 105 home office employees who comprise the Speakers Bureau are volunteers and receive no compensation for their platform appearances. One hundred and seventy-eight speakers have delivered more than 20 speeches each, while 38 of the 178 have delivered more than 50 each.

# EXPERIENCE WITH CARCINOMA OF THE COLON IN A COMMUNITY HOSPITAL

Vance Watt, M.D., *Thomasville*

- Early diagnosis and treatment are dependent upon increased public education.

CANCER OF THE COLON is one of the most important cancers that faces us today. There were 76,000<sup>1</sup> new cases in 1964, more frequent than any other site. It is second only to cancer of the lung as cause of death from cancer in the United States, causing 41,900 deaths in 1964. The fact that it is number two in cause of cancer death, rather than number one, brings up the second reason for its importance. The probability of cure following definitive surgery is quite high, especially when treated while still in the very early stage, while cancer of the lung has a very low five year survival rate, even when treated early. The third reason is the fact that most clinicians feel that the mortality rate from cancer of the colon can definitely be reduced by removal of polyps of the colon and rectum.

We realize that considerable doubt has been cast by Ackerman<sup>2</sup> and others on the theory that polyps of the colon are premalignant. Moretz<sup>3</sup> summarized the arguments for and against this theory. The arguments favoring this theory are:

1. The distribution in the colon is similar with the majority of cancers occurring in the distal colon.
2. Both occur in the same colon. Approximately 25% of cases with cancer have polyps and 6% to 11% of patients with polyps have cancer.
3. The peak age incidence is suggestive; that of polyps occurring nine to ten years earlier than that of cancer.
4. Familial polyposis patients die of cancer before age 40, if not treated.
5. Occasionally we see a cancer, where a polyp previously existed.
6. Carcinoma in situ is frequently seen in polyps, but rarely in other mucosa.
7. Small polyps seldom show cancer. The in-

cidence of cancer in polyps less than one cm. in diameter is less than 1%. Large polyps often show cancer. The incidence of cancer in polyps over 1½ cm. in diameter is 9% to 15%.

8. You practically never see a tiny cancer except in a polyp.

Arguments against this theory are:

1. In long term studies, observation of polyps has shown that the polyps remain polyps.
2. If polyps were precancerous, we should have more cancers. Eight per cent to 12% of people have polyps, but only 2% have cancer. However, in those people with polyps 5.8% have cancer.
3. Too few cancers show remnants of adenomatous polyps.
4. Ackerman and others feel that the distribution in the colon is different. He states that polyps are more diffuse in the colon, whereas cancer has a preponderance for the distal colon.
5. The sex incidence is different. The number of cases of cancer is almost equal between men and women, whereas the ratio of men to women with polyps is 1.3 to 1.

Until the question of the association between cancer and polyps is settled, we feel that we must assume there is a relationship and be on the alert for polyps in our patients.

Because of the importance of cancer of the colon, we decided to study the experience with this lesion in our hospital to evaluate our results. During the study period between April, 1954, and December, 1959, 83 cases were diagnosed as cancer of the colon or rectum. Three of these cases had to be thrown out, because of inadequate proof of the diagnosis, and four others had to be discarded, because they had definitive treatment elsewhere. This left

*Presented at the Annual Meeting of the Atlantic Coast Line Surgeons' Association, April 9, 1965, Naples, Florida.*



76 cases, which were given primary treatment for their cancer at Archbold Memorial Hospital. These cases were treated by seven different surgeons in their own private practice.

There were 34 males and 42 females; 62 white and 14 colored patients. Ninety-two percent of the patients were over 50 years of age with the greatest number (38.2%) between ages 60 and 69. The youngest patient was 31 years old and the oldest 86 with a mean age of 64.6 years. The primary symptoms were the same as in other series. Abdominal or rectal pain was found in 65.1% of cases; change in bowel habits in 52.6%; rectal bleeding in 46.1%; and one or more of the above symptoms in 93.4%. Duration of symptoms prior to treatment ranged from one day to four years with an average of 7.9 months. There were two patients with symptoms listed as four years in duration. One had pain only and the other had rectal bleeding at first, followed later by mucus and diarrhea. Even, if we were to exclude these two cases on the premise that their symptoms might have been due to something else in the earliest stages, the mean average of symptoms would still be 6.8 months. So we see that the treatment for these patients is being delayed too long after the onset of symptoms.

**Anemia More Prominent**

Anemia is reported as more prominent in cases of cancer of the right colon, than those of the left colon. We found this true in our cases, but not much more prominent. The lowest hemoglobin in the right colon lesions was 4 grams and that in the left was 3 grams. The highest was 14½ grams on the right side and 15 on the left. The average hemoglobin for right colon lesions was 9.4 grams and that on the left 11.0 grams. There were nine cases in the right colon with hemoglobin less than 10 grams and there were 12 cases in the left colon with hemoglobin less than 10 grams; half of these being above the recto-sigmoid junction and half below it.

In this series there were four adenomatous polyps with focal cancer, one villous or papillary polyp with focal cancer, 17 polypoid adenocarcinomas with no benign remnant, 34 annular lesions, one mucinous adenocarcinoma, and 19 unclassified tumors.

Figure 1 shows the location of the tumors in the colon. Only 60.5% were in the rectum and sigmoid. These figures include 79 cancers in 76 cases. One of the cases had two cancers, one in the splenic flexure and one in the sigmoid colon. Another case had three cancers, one in the splenic flexure and two in the descending colon near its proximal end.

The overall results of this review are summarized in Figure 2. The ten deaths shown occurred less than one month after onset of treatment. Five were in the group resected for cure and five in other cases. In

**SITE OF COLON CANCERS (A.M.H.)**

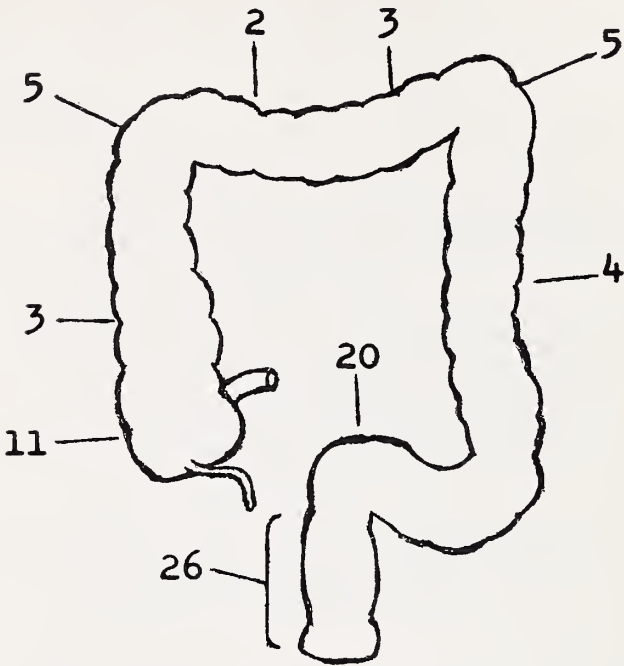


FIGURE 1

one case operation was not advised and the patient died of peritonitis from erosion of the tumor into the peritoneal cavity. Another was explored and found not to be resectable. A proximal colostomy was performed and she did well for about a week, only to develop peritonitis from erosion of the tumor into the peritoneal cavity, leading to death. Three cases were treated by decompression only, because of intestinal obstruction secondary to advanced tumor. The cause of death was directly related to the tumor. In the five cases operated on with intent to cure, two died of shock, one had an embolus post-operatively, one died of pneumonia and uremia, and another was uremic with aspiration of vomitus apparently the terminal event. Figure 3 shows the five year survival summary. The over all five year survival was 30.3%. The over all five year survival rate in those resected with intent to cure was 56.1%. If we eliminate the five cases dying within one month

FIGURE 2  
RESULTS AND MORTALITY FACTORS

	No.	%
Patients Seen	76	100.0
Refused Operation	3	3.9
Operated	68	89.5
Resected	51	66.4
Resect to Cure	41	53.9
Palliative Operation	10	13.2
Mortality	10	13.2
Follow-up	76	100.0
2 Yr. Survival	32	42.1
5 Yr. Survival	23	30.3

after operation, the relative five year survival rate among the cases resected with intent to cure was 63.9%. The over all five year survival rate of all cases showing intestinal obstruction at the time of treatment was 32.0%. However, among those cases of obstruction, which were resected with intent to cure, there was a 67.0% 5 year survival rate.

Another interesting observation is the relationship between the stage of the disease and the five year survival rate. Seventeen cases showed the tumor to be confined to the bowel with no evidence of invasion of the serosa or spread to the lymph nodes. In this group the five year survival rate was 70.6%. In those 16 cases which showed serosal invasion but negative nodes, the five year survival rate was 53.0% and in those eight cases, which showed positive nodes, the five year survival rate was 25.0%. When compared with the series recorded by Swinton<sup>4</sup> and by Madden,<sup>5</sup> these figures are in line with theirs. In their series, however, the cases were not broken down into three groups. They just listed them as localized or with positive nodes. The former quoted a five year survival rate of 63.7%, when the disease was still localized and 29.2%, when there were positive nodes. The latter's figures were 50.4% and 20.3% respectively.

Figure 4 compares our results with several other reports.<sup>5, 6, 7</sup> In our series 53.9% were resected with intent to cure as compared with 62.4% and 68.2% in two of the other series. The absolute or over all five year survival rate was 30.3% in our series as compared with 28.0%, 23.9%, and 40% and the relative five year survival rate, that is the five year survival rate in those resected with intent to cure, was 56.1% as compared with 46.0%, 35.1% and 57%.

The figures quoted by Welch<sup>7</sup> in The Massachusetts General Hospital series are interesting. He compares one series of cases in that hospital between 1937 and 1948 and another series between 1949 and 1960. Through the efforts of doctors, the American Cancer Society, and other groups, people came earlier for treatment in the second group than in the first one. The average time between onset of symptoms and treatment was seven months in the first

group and three months in the second, and this is reflected in the observation of these cases. In those cases resected with intent to cure negative nodes were found in 59% of cases in the first group and 68% in the second group. Among all cases, negative nodes were found in 37% of the first group and 46% of the second group, and the absolute five year survival rate was 25% in the first group and 40% in the second group. This certainly shows the importance of early treatment of these cases.

Comment

This review of our cases does not show any startling facts and is certainly nothing to brag about, but it does reemphasize the need for earlier diagnosis and treatment of cancer of the colon. The average length of time between onset of symptoms and definitive treatment is far too long. Part of the blame for this lies on the patient, but physicians must accept some of the blame too.

What can we do to bring the victims of this disease to early treatment? First, we can encourage the patient to seek treatment early by recognizing the early symptoms of colon cancer and to seek help immediately.

In doing this we should:

- 1. Inform our patients of the signs and symptoms to watch for.
- 2. Help them to realize that cancer of the colon can be cured, if treated early.
- 3. Try to remove or lessen the patient's fear of visiting his physician to investigate suspicious symptoms.
- 4. Encourage our patients to have regular check-ups.
- 5. Encourage educational campaigns for the public, such as that put on by the American Cancer Society.

Next, we as physicians must do our part. When the patient comes to us, we should take the following steps:

- 1. Include a digital rectal examination and sigmoidoscopic examination in all routine physical examinations.
- 2. Also include a barium enema examination on

FIGURE 3  
5 YEAR SURVIVAL SUMMARY

	%
Overall .....	30.3
Operated to Cure .....	56.1
Survived Cure Operation .....	63.9
Obstructed—Overall .....	32.0
Obstructed—Operation to Cure .....	67.0

FIGURE 4  
COMPARISON WITH NATIONAL FIGURES

	Hartford 1950 %	A.M.H. 1959 %	Madden 1959 %	Welch 1960 %
Resect to Cure .....	62.4	53.9	68.2	
5 Year Survival				
Absolute .....	28.0	30.3	23.9	40
Relative .....	46.0	56.1	35.1	57



all patients with a change in bowel habit, rectal bleeding, unexplained anemia or unexplained abdominal or rectal pain. We have long felt that routine barium enema examination should be included in routine physical examinations, at least every other year, even though no symptoms are present. The big question was at what age this routine examination should start. We, therefore, decided to review the age distribution of our cases as well as other series. It was noted in our series that only four of the cases were in patients under 50 years of age. Other series revealed a higher incidence in the age 40 to 49 group than ours did. We added to our group the cases of Spratt,<sup>2</sup> Madden,<sup>5</sup> and Stanford.<sup>8</sup> The total cases in these four series showed 33 cases under 40 years of age, 79 cases between 40 and 49 years of age and 599 cases 50 years old and over. Spratt, Ackerman and Moyer<sup>2</sup> show a table which shows the age adjusted incidence of cancer of the colon and rectum in a standard population of 1,000,000 people, computed from Public Health monograph number 29 in 1955. These figures show 21 cases under 40 years of age, 50 in the age 40 to 49 year group, and 382 in the 50 and over group. It is interesting to note that these separate groups of cases show almost identical age distribution with 4.6% under age 40 and slightly over 84% age 50 and over. See Figure 5. This would indicate that it would be impractical to do routine barium enema examinations on patients under 40 years of age and of questionable value in the group 40 to 49 years of age. However, it would seem extremely important to do barium enema examinations on all patients 50 years old and older, at least every two years, whether they have symptoms or not.

3. Don't assume that rectal bleeding in the presence of hemorrhoids is due only to hemorrhoids.
4. Don't assume that rectal bleeding in children is due to constipation, anal fissure, etc. It could be due to a polyp or even cancer. Goodwin and Gay<sup>9</sup> reported a case of cancer of the colon in an 11 year old boy and found 71 cases in the literature in children, the youngest of which was three years old. We also recently had a case of cancer of the colon in a 19 year old colored male.
5. Carry out an anti-polyp campaign in own practice, remembering that the incidence of cancer in polyps over 1½ cm. is 9 to 15%,<sup>2</sup>

FIGURE 5  
AGE INCIDENCE COLON CANCERS

	All Cases		Standard	
	No.	%	No.	%
Under 40 .....	33	4.6	21	4.6
40 to 49 .....	79	11.1	50	11.0
50 and Over .....	599	84.2	382	84.3

that the incidence where several polyps are present, is higher than this, and that those cases of familial polyposis untreated will all be dead by 40 years of age.

6. Don't forget that cancer develops in about 1 out of 6 cases of chronic ulcerative colitis, not treated by colectomy, and that although the average time of onset of cancer is 9 years after onset of symptoms, it may be less than 1 year after onset.<sup>10</sup>
7. Remember that patients treated for colon cancer and polyps should have appropriate periodic follow-up studies.

If we carry out the above measures and see that all suspicious lesions are properly treated, the number of people dying each year from cancer of the colon could be significantly reduced.

### Summary

The experience with the treatment of cancer of the colon in a community hospital has been reviewed. It is suggested that further attempts at public education and use by the physician of procedures and information readily available could significantly reduce the present mortality rate from cancer of the colon.

900 Gordon Avenue

### REFERENCES

1. Georgia Division American Cancer Society—Personal Communication.
2. Spratt, J. S.; Ackerman, L. V., and Moyer, C. A.: Relationship of Polyps of Colon to Colonic Cancer; *Annals of Surgery* 148:682-696, July-December, 1958.
3. Moretz, William H.: Personal Communication.
4. Swinton, N. W. and Farha, G. J.: Recent Trends in the Treatment of Cancer of the Colon and Rectum; *Lahey Clinic Bulletin* 13:64-70, July-September, 1963.
5. Madden, J. L. and Lee, B. Y.: Cancer of the Colon; *American J. Surg.* 107:346-352, Feb., 1964.
6. Wilson, J. S. and Tennant, R.: Carcinoma of the Colon: A Ten Year Study; *Cancer* 11:278 (March-April), 1958.
7. Welch, C. E.: The Diagnosis and Treatment of Cancer of the Colon and Rectum; *Cancer* 15:155-159, July and August, 1962.
8. Stanford, W. and Lawton, R. L.: Carcinoma of the Colon: A Review of 87 Patients; *J. Iowa Med. Soc.* 53:795, Dec., 1963.
9. Goodwin, B. D. and Gay, B. B.: Carcinoma of the Colon in Childhood; *Bulletin of Emory University Clinic* 4:14-17, August, 1964.
10. Welch, C. E. and Hedberg, S. E.: Colonic Cancer in Ulcerative Colitis and Idiopathic Colonic Cancer; *J.A.M.A.* 191:815-818, March 8, 1965.

# DIAGNOSIS AND TREATMENT OF CONVULSIVE DISORDERS IN CHILDREN

Richard J. Allen, M.D.

*Ann Arbor, Michigan*

- Phenobarbital, Dilantin, and Tridione  
when employed properly will control  
a high percentage of seizure disorders.

CONVULSIONS are a common neurological symptom in children, and because of this importance a number of excellent texts are devoted solely to this topic.<sup>1</sup> When seizures occur, traditionally a great concern for an underlying brain tumor exists, but with increasing experience we have learned that this is a rare and unnecessarily overemphasized possibility. The majority of children who have etiologically unidentifiable seizures, although a symptomatic relationship to infection and a variety of other presumed causes, is common. The key problems to consider in convulsive disorders of children include proper medical management, in particular the selection of anticonvulsant drugs to be administered over long periods of time, along with consideration for the associated social and economic stigmata. Proper parent, patient and community education is also very essential.

## No Single Drug

From time to time new drugs are introduced with overenthusiastic claims and patients often further overinterpret these reports. However, it is doubtful that any single drug will in the near future become a panacea for convulsive disorders, especially in view of the multiple causes in this age group. The patient should know that while new drugs are regularly introduced few have the value of Phenobarbital, Dilantin and Tridione which form the basic armamentarium of the practicing physician. When these drugs are properly employed they will serve the majority of seizure disorders of this young age group, but re-

sistant cases, of course, require closely supervised alterations in the anticonvulsant regimen. Surgical techniques have also been used especially in adult seizure disorders, but for many reasons this method of management has been less useful in the pediatric age group.

Not uncommonly a child with a seizure disorder is completely free of attacks while under proper medical care and may be normal in every way. However the exaggerated fear of "epilepsy" in the school and in the community often affects the child's total adjustment. In older age groups archaic marital and driving laws have further interfered with the social and economic success of the adolescent and young adult.<sup>2</sup>

Seizures in infants and children are not often equated with "epilepsy" because a greater susceptibility is generally expected. Therefore when a child develops a convulsion with a fever due to infection, it is assumed that there is a difference in susceptibility to infection or that there is a greater thermolability in addition to central nervous system immaturity. However, since the number of children affected with seizures sometime in their lives is greater than among adults, such attacks suggest some basic central nervous system difference besides "immaturity" from the innumerable children who under similar circumstances do not respond to infection with convulsions.

In the Pediatric Neurology Seizure Unit at the University of Michigan Medical School 1,763 infants and children were seen in the five year (Figure 1) period, from 1957 to 1962 with seizure disorders. Over one half of these children had grand mal seizures although petit mal and focal motor seizures were also quite common. A large number of children had subjective symptoms that could not easily be de-

*Director Pediatric-Neurology Unit, Department of Pediatrics, University of Michigan Medical School.*

*Presented at the Sixteenth Annual Session of the Georgia Academy of General Practice, October 9, 1964, Augusta, Georgia.*



defined as seizures, such as headaches, syncope, or abdominal pain.

While grand mal seizures are the most common variety at any age, they are particularly prominent in the first two years of life (Figure 2). This figure emphasizes the temporal relationship of certain types of seizures. For example, myoclonic seizures often called "head nodding attacks," "infantile spasms," or "lightening major seizures," are confined almost entirely to the first two years of life. Similarly psychomotor seizures are not usually clinically identifiable below the age of three years. An awareness of this age distribution may help in the clinical diagnosis of seizure type and etiology.

Associated Neurological Symptoms

While convulsions suggest a "cerebral lesion" many seizure syndromes represent diffuse anatomical or physiological central nervous system involvement rather than a localized defect where a tumor might be suspected. Massive myoclonic seizures in infancy for example, are the result of diffuse brain involvement which can also be shown electroencephalographically.<sup>3</sup> Therefore these attacks should suggest a diffuse metabolic or post infectious etiology rather than some localized abnormality where surgical intervention would be considered. Petit mal seizures are also characterized by diffuse paroxysmal electroencephalographic discharges of subcortical origin so that there is little concern generally about a localized mass lesion. Focal seizures on the other hand may be associated with localized anatomical and electroencephalographic changes. However, children are often unique in that electrical foci detected in the electroencephalogram frequently shift from one area to another or from one hemisphere to another over a period of time so that the search for "a lesion" is often without success. Grand mal seizures may originate from either generalized or focal brain disorders, but in children they usually indicate a diffuse disorder that is clinically classified as "idiopathic epilepsy."

Therefore while a seizure may suggest the extent and degree of cerebral involvement it may also shed some light on the type of organic involvement of the brain. A number (Figure 3) of organic brain disorders (mental retardation, behavior disorders, etc.) appear to be related to the type of clinical seizures. Massive myoclonic seizures, for example, in infancy are commonly associated with serious intellectual impairment and diffuse organic central nervous system involvement. Also a large number of children with grand mal seizure disorders have had a history of "febrile convulsions" and within this group a significant percentage have demonstrated organic disorders of the brain suggesting that a convulsion with

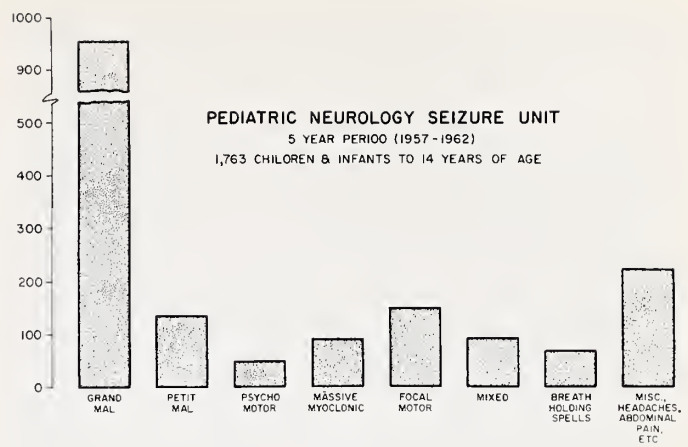


FIGURE 1

Distribution of seizure disorders evaluated over a five year period. (1957-1962)

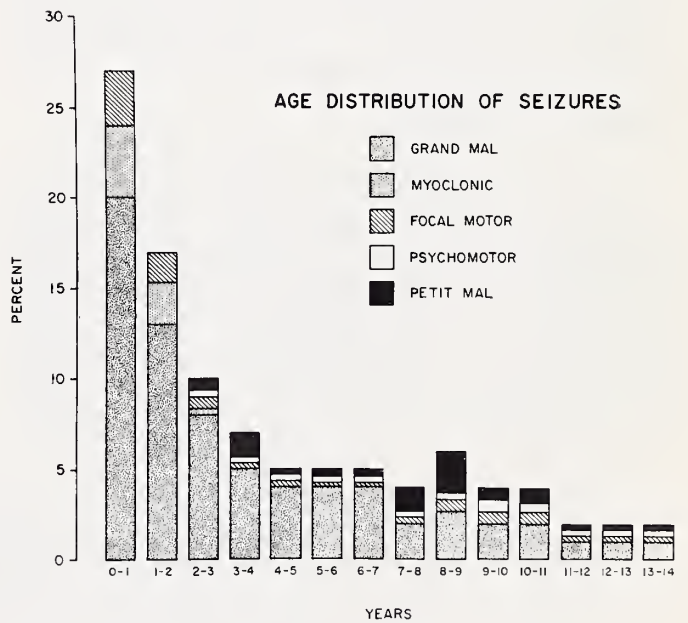


FIGURE 2

Distribution of seizure types according to age.

ASSOCIATED FINDINGS IN SEIZURE DISORDERS			
	% Family History	% History of Febrile Seizures	% Organic Brain Disorders
Grand Mal	49	31	30
Petit Mal	40	14	30
Psychomotor	51	18	28
Massive Myoclonic	47	6	80
Focal Motor	43	5	50

FIGURE 3

fever can be a manifestation of a more serious underlying brain disorder. Subsequent behavioral and intellectual abnormalities have also become apparent in children originally presenting with only a seizure problem. These observations suggest that the occurrence of a seizure in a child should not be disregarded in terms of total neurological intactness, although at the time of the major seizure or shortly thereafter no demonstrable neurological abnormalities may be apparent. Long term follow-up may eventually demonstrate abnormalities that will seriously influence either academic or social development. The occurrence of seizures later in adult life is another risk for children who have seizures of any type early in life. The most uncommon occurrence in our experience is the development of a brain tumor in a child with only a convulsion as an initial manifestation. Although a number of neurological risks are associated with the occurrence of seizures in infants and children, a great many spontaneously subside with the passage of time without further neurological involvement.

Laboratory Studies

It is traditional to obtain a blood calcium, fasting blood glucose and blood urea nitrogen levels in the evaluation of a newly developed convulsive disorder. However these children frequently appear in our Seizure Clinic at some time after the occurrence of the initial neurological symptom and metabolic appraisals are often not fruitful. Certain studies are especial-

ly important, such as a cerebral spinal fluid analysis at the time of a febrile seizure to be certain that a central nervous system infection does not exist. Skull x-rays are important but can be done at the discretion of the physician especially in infants and young children. Glucose tolerance studies including the search for leucine sensitive hypoglycemia cannot be done routinely unless a suspicion of a metabolic disease is derived from other clinical or laboratory evidence. Hypoglycemia in infants with convulsions is especially important to consider, and in new born babies recent evidence has re-emphasized the value of blood glucose studies.<sup>4</sup> On the other hand, occasionally children with continuous convulsions will develop a temporary hyperglycemia probably related to adrenalin release, that may mislead the physician in initial laboratory studies.

The use of electroencephalography (EEG) is a basic laboratory tool in the evaluation of most seizure disorders. Not only may such a tracing aid in the localization of a mass lesion, but it will often specifically identify certain types of seizure disorders. Brief "staring attacks" for example may only be day-dreaming episodes of inattention, but electroencephalographically are often shown to be a typical petit mal convulsive disorder with a characteristic spike wave configuration (Figure 4). However electroencephalograms are technically difficult to accomplish in young children for lack of cooperation and the problem may be amplified when intellectual limitations alter the cooperation of the patient. There is also considerable variation in the electroencephalographic tracing of an infant compared to an older

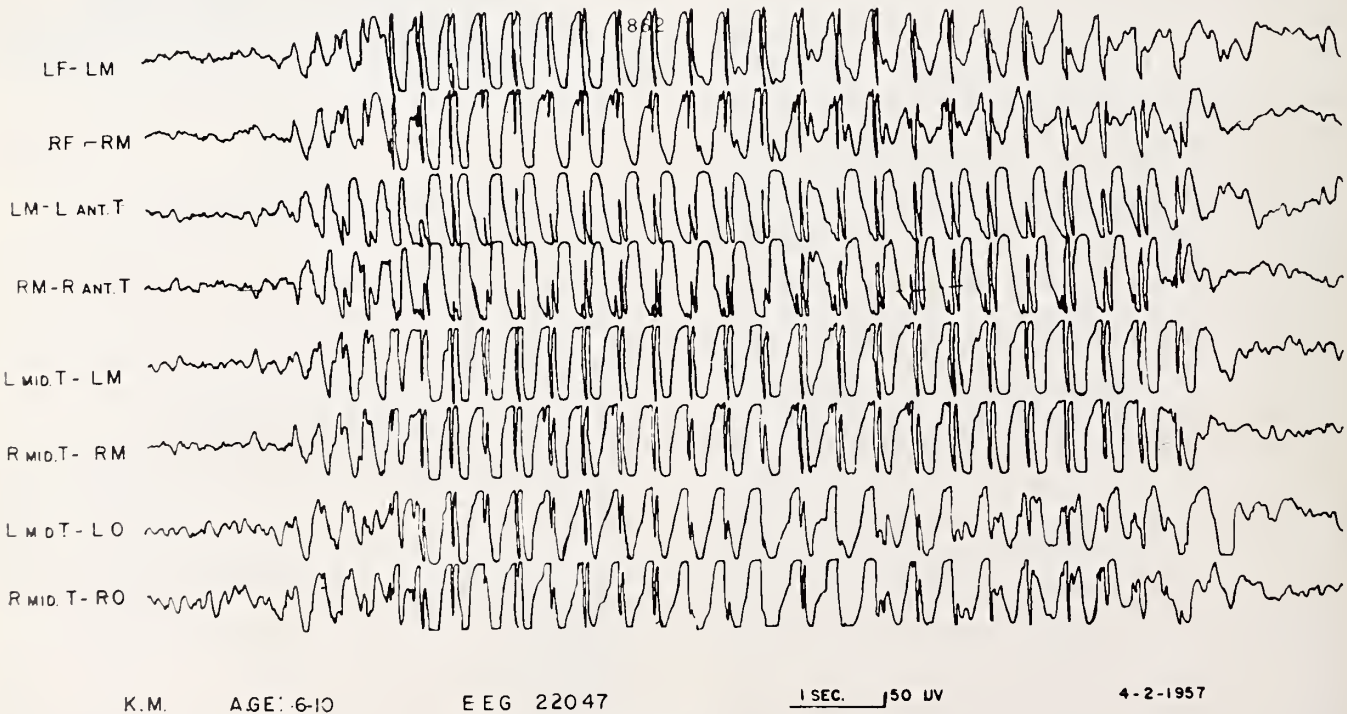


FIGURE 4  
Typical electroencephalogram in petit mal seizure disorders.



child or adult, and therefore, pediatric electroencephalography requires considerable experience and knowledge of maturational differences. Some examples of electroencephalograms will illustrate the value of this procedure in delineating the seizure problem since certain seizures have characteristic tracings especially when obtained during the attack. On the other hand many kinds of seizures, such as grand mal attacks in infants and children do not occur at the time of the recording and are therefore evaluated in an inter-seizure period. Occasionally in this group of patients a seizure may be purposefully induced by a flickering light, hyperventilation or rarely by the use of drugs. Hyperventilation is used routinely in many laboratories and is particularly valuable in precipitating a petit mal attack. Petit mal seizures are characterized by a typical three cycle per second spike wave discharge as seen in Figure 4. Inter-seizure recordings in grand mal disorders are not infrequently associated with only minimal electroencephalographic changes. Myoclonic seizures or "infantile spasms" represent a unique disorder in infancy and frequently are associated with a typical electroencephalogram (Figure 5) called "hypsarrhythmia" where the discharges are of high voltage and have a slower than normal frequency. The proper classification of this particular seizure disorder may be helpful in medical prognosis and in therapeutic decisions.

The previous emphasis on laboratory examination in no way minimizes the importance of adequate clinical appraisal by physical and neurological examina-

tions and histories. Each child should be completely examined to exclude obvious causes. When a seizure is brought to the attention of the physician, he should take particular note of the developmental milestones and when the infant has recovered from the seizure, an effort should be made to delineate intellectual competence by clinical appraisal and when possible psychological testing. Often the physician's interview with the family will be the best source of information in establishing the type of seizure disorder. It is especially important to determine the presence or absence of consciousness during the attack in addition to evaluating focal signs such as unilateral convulsions or automated activities. The presence or absence of bladder or bowel incontinence cannot be retained as a classical sign particularly in young patients. The identification of a seizure in a very young infant below the age of one year may be extremely difficult since irregular motor activity is common and it may be impossible to estimate the degree of a mental alertness at the time of an attack.

### Anticonvulsant Therapy

Proper medical care of a child with a seizure disorder embodies a number of medical approaches including parent and patient counseling. As a child becomes older, working with community resources and school authorities also becomes increasingly important. Aiding the young adolescent and adult to live normally with a seizure disorder cannot be minimized. However, the proper selection of anticonvul-

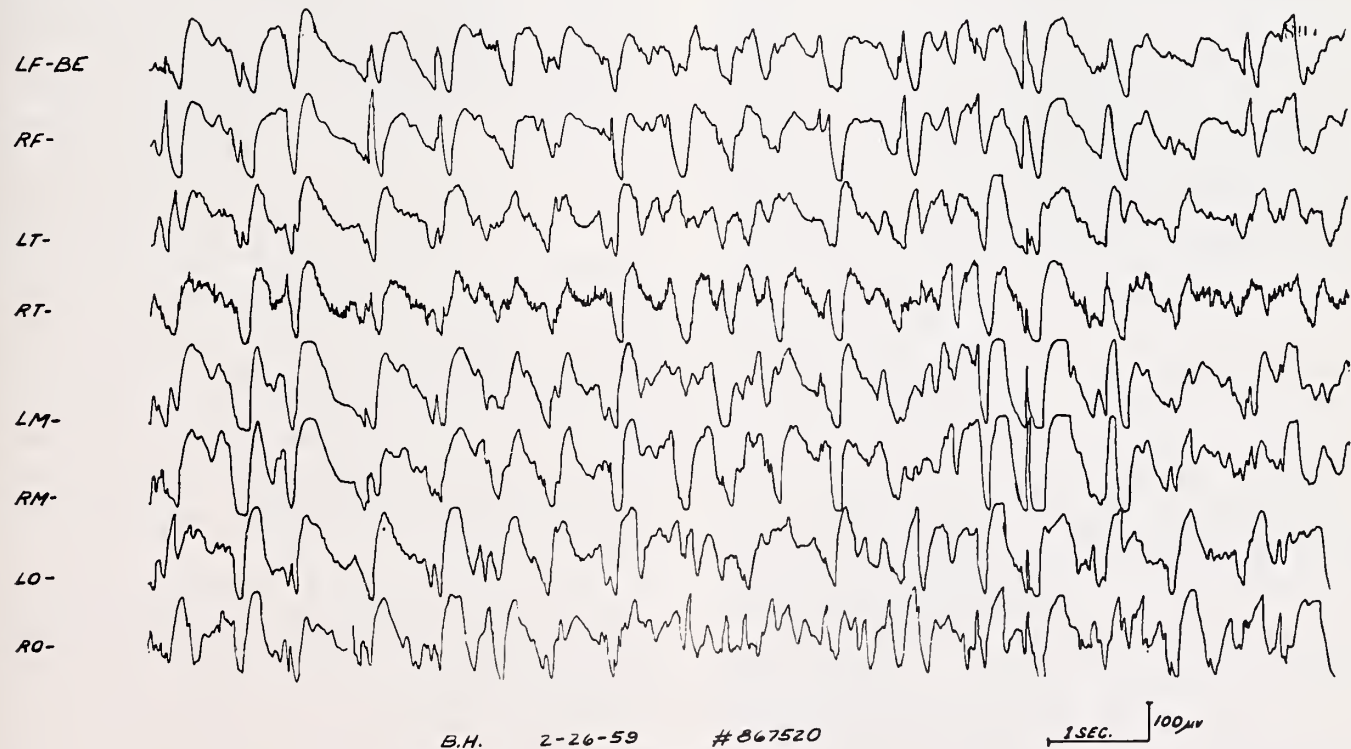


FIGURE 5  
Typical electroencephalogram (hypsarrhythmia) in infantile myoclonic seizure syndrome.

sant drugs will be particularly stressed in this brief presentation.

While medications in children are frequently selected on a weight basis, there is considerable variation in drug tolerance especially with anticonvulsants so that alterations should be guided by the patient's response in terms of seizure control and induced toxicity. The arbitrary limitation of some drugs to low levels based on a weight basis may exclude the only effective drug in a child where seizure control is otherwise impossible. Ease of administration is also of high priority in any medical recommendations for the use of anticonvulsants. Liquid preparations are not necessarily best in infants and children because crushed tablets are often more easily disguised and the dosage more accurately controlled. Also a tablet administered once a day particularly at night before retiring has a greater potential for long term treatment than when given unnecessarily three or four times a day.

### Drug Treatment for Major Seizures

Grand mal, focal motor, psychomotor and to a lesser extent myoclonic seizures of infants and children respond best to drugs of the barbiturate and hydantoin category. Phenobarbital and Dilantin have become the basic drugs of choice, not only because of effectiveness but also because of lower cost and toxicity when compared to other compounds. Since these particular types of seizures represent the largest group encountered in clinical practice, a thorough acquaintance in the use of Phenobarbital and Dilantin will serve many clinical situations. Phenobarbital may be given in amounts of 32 milligrams to 100 milligrams a day depending on the child's age. This medication may be given in a single dose at night before retiring particularly where the seizure threshold is relatively high and seizures are infrequent. Where seizures become more difficult to control more frequent administration of greater amounts is indicated. Phenobarbital, however, need not cause sedation to be effective as an anticonvulsant and it also has a longer duration of anticonvulsant action than is generally realized. The elixir has an unpleasant taste while crushed tablets can be mixed with foods and will meet less resistance from patients. Many seizure disorders of infants and children can be managed with a single dose of Phenobarbital each night before retiring. The routine administration of Phenobarbital two or three times a day is in itself discouraging especially when seizures are infrequent. If after an adequate trial (e.g. several months) of a single drug the seizures continue, other anticonvulsants must be added or substituted.

Dilantin sodium is a hydantoin which was intro-

duced in 1934 and is still one of the most effective anticonvulsants known, for it is associated with little if any sedation and is generally well tolerated in all age groups. The tablet form is particularly effectively used in children because of its pleasant taste and ease of administration so that dosage accuracy can be maintained. The liquid suspension has limited value, for although it appears to be the best preparation for an infant or young child, it is extremely thick liquid which is difficult to measure. The liquid preparation is prepared in a concentration of 100 milligrams per four milliliters while the average teaspoon in the home contains five milliliters. Because of thickness, it is possible to over-fill a teaspoon so that 25% to 50% overdosage occurs.

### Frequent Administration Unnecessary

The amount of Dilantin to be given per day may vary from 25 milligrams in the infant to 300 milligrams per day in the older child of six to seven years of age. Because of slow tissue absorption and excretion, frequent administration of Dilantin is unnecessary so that a single dose may be an effective therapeutic regimen. Major toxic side effects of overdosage include ataxia with nystagmus and slurring of speech, generalized rashes, gum hypertrophy and hirsutism and most, if not all of these, will disappear when the dosage is reduced.

Anticonvulsant drug selection is often difficult for minor seizures such as petit mal attacks in the four to eight year age group and myoclonic seizures in infancy so that these syndromes are one of the most difficult disorders a physician has to deal with. Tri-dione is especially useful in petit mal attacks and is available in tablet, liquid and capsule form. Again the tablet form is easily administered and can more accurately be quantitated. The amount to be given in young children varies from 150 milligrams three times a day to 600 milligrams three times a day in older children. While leukopenias occasionally occur, some reduction in medication is generally all that is necessary and discontinuation of therapy is advisable only when the white blood cell count falls below 4,000 cells per cubic millimeter. The mild side effects include hiccups and photophobia but do not generally require stopping therapy. Other drugs should be considered either in combination or alone when Tri-dione is ineffective.

Steroid treatment in infantile spasms (hypsarrhythmia) is still of questionable value. The original reports<sup>5</sup> indicated considerable value in this syndrome while a more recent study<sup>6</sup> suggests that while the seizure may be modified there is no significant alteration in the basic brain damage. Our experience over the past six years with these infants has led us to believe that oral steroid therapy is more effective than injec-



tion ACTH and that large doses over long periods of time are necessary to obtain significant results. When a typical EEG is obtained in an infant between three to eight months of age associated with typical myoclonic jerking, 32 milligrams of methylprednisolone (Medrol\*) is prescribed daily for periods of two to six months. The dosage is gradually reduced to 16 milligrams under electroencephalographic and clinical supervision. This particularly tragic syndrome occurring in young infants who have previously been normal is still a perplexing clinical problem but worthy of steroid therapy unless a specific etiology is discovered that would suggest a different therapeutic attack.

## Other Drugs

New anticonvulsant drugs are constantly being introduced for seizure control so that physicians should be cautioned against changing medications in a seizure controlled child to a new and partially tested preparation. Toxic effects in particular require years of observation for proper evaluation. Also rapid drug changes in anticonvulsant regimens should be avoided and considerable overlap between the drug to be withdrawn and the new drug to be added is axiomatic. Some newer drugs hold promise of improving the armamentarium of the physician dealing with seizure disorders. We have found acetazolamide (Diamox†) to be a valuable potentiator of many anticonvulsants especially Phenobarbital and Dilantin when given in amounts of 125 to 250 milligrams three times a day.<sup>7</sup> A newly introduced succinimide (Zarontin‡) has also proven to be very effective in petit mal seizures.<sup>8</sup> In rare instances children are uncontrollable with presently available anticonvulsants and such formidable regimens as a ketogenic diet must be considered.

\* Upjohn Company.

† Lederle Company.

‡ Parke, Davis & Company.

Seizures in children are a common neurological symptom and it is the role of the physician to allay the apprehension of the family and community when a child is suddenly found to have such a disorder. By tradition convulsions frequently imply a brain tumor or "deterioration" with intellectual incompetence. But while seizures may indicate the presence of other neurological changes many children have convulsive disorders without associated defects.

Children with seizures can effectively be evaluated by clinical examinations which include detailed histories, but electroencephalography has broadened our understanding of seizures and aided proper seizure classification and drug selection. A few basic drugs are best employed in most pediatric seizure disorders and when administered in convenient dosages at infrequent intervals there is an improved rate of long term therapy which aids seizure control and increases the neurological potential of the patient. Phenobarbital, Dilantin and Tridione represent a basic armamentarium for the practicing physician and when employed properly will control a high percentage of seizure disorders.

## REFERENCES

1. Livingston, Samuel: *The Diagnosis and Treatment of Convulsive Disorders in Children*; Thomas, Charles C, Springfield, Illinois, 1954.
2. Barrow, Roscoe, and Fabing, Howard: *Epilepsy and the Law*; Hoeber-Harper Book, New York, 1956.
3. *Atlas of Electroencephalography Vol. II, Epilepsy*; Addison-Wesley Publishing Co., Inc., London, England, 1952.
4. Cornblath, Marvin; Wybregt, Susan; Baess, Gloria, and Klein, Reuban: Symptomatic Neonatal Hypoglycemia: Studies of Carbohydrate Metabolism in the Newborn Infant VIII; *Pediatrics* 33:388, March, 1964.
5. Sorel, L. L.: *Treatment of Hypsarrhythmia With ACTH*; in *Brain Research Foundation, Molecules and Mental Health: Ed. I*; Edited by F. A. Gibbs, Philadelphia, Lippincott, 1959, p. 114.
6. Bray, Patrick F.: The Influence of Adrenal Steroids and Corticotropin on Massive Myoclonic Seizures of Infancy; *Pediatrics* 32:169, August, 1963.
7. Bacon, George, and Allen, Richard: *Metabolic and Central Nervous System Effects of Diamox in Epileptic Children* (in press).
8. Weinstein, Anita, and Allen, Richard: *Ethosuximide in the Treatment of Petit Mal Seizures in Children* (in press).

## EMORY TO HOLD POSTGRADUATE CONFERENCE ON GYNECOLOGIC CANCER THIS FALL

The Department of Gynecology and Obstetrics of Emory University School of Medicine will sponsor, in association with the Georgia State Obstetrical and Gynecological Society, a Postgraduate Conference in Gynecologic Cancer on November 15, 16, and 17, 1965. Guest Faculty participating in the two and one half day conference includes: Drs. Hans L. Kottmeier of Stockholm, Sweden; Felix Rutledge of Houston, Texas; Denis Cavanagh of the University of Miami School of Medicine and Walter T. Murphy, of the Buffalo General Hospital, Buffalo, New York. Members of the Emory Faculty from the Department of Gynecology and Obstetrics and the Department of Radiology

will also be included on the program.

This conference is number six in Gynecology-Obstetrics offered at Emory for physicians in private practice and, as previous ones, will be held in Grady Memorial Hospital Auditorium.

A descriptive brochure, including an advance registration form, is now being distributed explaining all particulars of the program. Due to limited seating, attendance will have to be limited to 300.

Physicians desiring additional information are invited to write: Gyn-Ob Postgraduate Education, Emory University School of Medicine, 69 Butler Street, S.E., Atlanta, Georgia 30303.

## **LOMOTIL** *Pharmacologic Activity*

The significant pharmacologic actions of Lomotil are summarized as follows:

Evidence indicates that Lomotil acts directly by inhibiting excess peristalsis.

Lomotil is not known to inhibit nonpropulsive intestinal movements.

Roentgenograms demonstrate that this activity occurs within two hours after oral administration and persists for at least six hours.

Comparative studies in the rat show Lomotil to be more effective in inhibiting fecal excretion than either codeine or morphine.

Analgesic, anticholinergic, mydriatic and gastric secretory effects have not been significant.

Reduction of propulsive motility with Lomotil relieves spasm and cramping, allows physiologic absorption of fluid and reduces frequency of evacuations to provide prompt, symptomatic control of virtually all diarrheas.

# LOMOTIL<sup>®</sup>

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride .....2.5 mg.

(Warning: May be habit forming)

atropine sulfate .....0.025 mg.

tablets • liquid



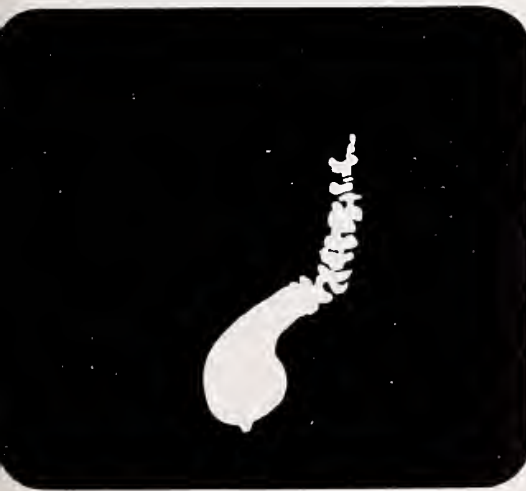
**slows propulsion**



**relieves distress**



**stops diarrhea**



**Precautions:** Lomotil is an exempt narcotic preparation of very low addictive potential: more than three million prescriptions have now been written for Lomotil. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

**Side Effects:** Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

**Dosage:** For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses*, until diarrhea is controlled, are:

**Children:**

- 3 to 6 months—3 mg. (½ tsp.\* t.i.d.)
- 6 to 12 months—4 mg. (½ tsp. q.i.d.)
- 1 to 2 years—5 mg. (½ tsp. 5 times daily)
- 2 to 5 years—6 mg. (1 tsp. t.i.d.)
- 5 to 8 years—8 mg. (1 tsp. q.i.d.)
- 8 to 12 years—10 mg. (1 tsp. 5 times daily)

**Adults:**

- 20 mg. (2 tsp. 5 times daily or
- 2 tablets 4 times daily)

*\*Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

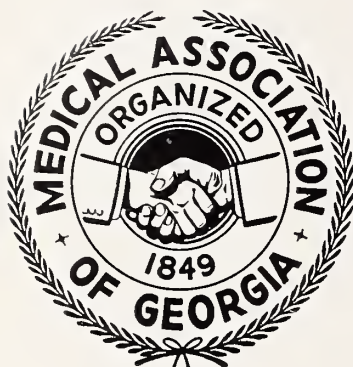
Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

**SEARLE**

*Research in the  
Service of Medicine*

# 1966 Annual Session

May 8-10, 1966 – Columbus, Georgia



## Last Call for Scientific Papers

All titles must be submitted to the  
respective program chairmen listed  
below before November 1, 1965

### SPECIALTY SOCIETY SCIENTIFIC SECTION PROGRAM CHAIRMEN

#### ANESTHESIOLOGY

Dan C. Newberry, M.D.  
Doctors Building  
Columbus

#### CHEST

Robert H. Vaughan, M.D.  
Physicians Building  
Columbus

#### DIABETES

Harry Brill, M.D.  
Doctors Building  
Columbus

#### DERMATOLOGY

Edgar B. Smith, M.D., Major, (MC)  
Martin Army Hospital  
Ft. Benning, Georgia

#### GENERAL PRACTICE

George D. Schuessler, M.D.  
Doctors Building  
Columbus

#### MEDICINE

Simone Brocato, M.D.  
Physicians Building  
Columbus

#### OBSTETRICS AND GYNECOLOGY

John R. McCain, M.D.  
384 Peachtree Street, N.E.  
Atlanta

#### OPHTHALMOLOGY AND OTOLARYNGOLOGY

Lionel Yoe, M.D.  
Doctors Building  
Columbus

#### ORTHOPEDICS

George Whatley, M.D.  
1316 13th Avenue  
Columbus

#### PATHOLOGY

Agatha Thrash, M.D.  
St. Francis Hospital  
Columbus

#### PEDIATRICS

A. J. Kravtin, M.D.  
204 11th Street  
Columbus

#### PSYCHIATRY

Leonard T. Maholick, M.D.  
1327 Warren Williams Rd.  
Columbus

#### RADIOLOGY

George M. Hutto, M.D.  
1444 Fourth Avenue, Columbus

#### SURGERY

S. A. Roddenbery, M.D.  
711 Center Street  
Columbus

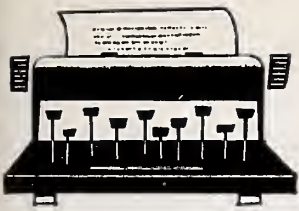
#### UROLOGY

Franklin D. Edwards, M.D.  
1430 Third Avenue  
Columbus

#### PUBLIC HEALTH

Joe A. Bain, M.D.  
P. O. Box 2299  
Columbus





## Recent Trends in Venereal Disease Rates

**T**HE AMA has just announced that it is launching an intensive "Health Education Campaign to Combat Venereal Disease." It has also scheduled an "AMA National Symposium on Venereal Disease Control" to be held in Chicago on November 20, 1965.

This action by AMA has been prompted by the alarming increase in infectious syphilis (primary and secondary) reported by the U. S. Public Health Service. Since 1957, reported cases and/or rates for primary and secondary (infectious) syphilis in the United States have increased by more than 300%.

Still more disturbing is the fact that primary and secondary syphilis rates among teenagers for the same period of time have increased more than 200%. Public Health Service statistics also show an appreciable, but less dramatic, rise in gonorrhea rates over the same period of time.

What has happened in Georgia over this same period of time?

### Increase of 100%

Primary and secondary (infectious) syphilis increased by a little more than 100% between 1955 and 1964. Georgia statistics for 1965 show a *10.8% decrease in primary and secondary syphilis* over 1964. Unlike the rest of the nation, Georgia has experienced no rise in teenage VD (syphilis and/or gonorrhea) since 1957. Georgia will probably be the first major problem area to show a reversal in the upward trend in the rates of primary and secondary syphilis. This decrease in primary and secondary syphilis in 1965 is attributed to "epidemiologic treatment"—the treatment of all named sex contacts to primary and secondary syphilis within the incubation period who are clinically and serologically negative upon initial examination. During 1965, 91% of such contacts received epidemiologic treatment (usually 2.4 million units of Bicillin).

Since 1955 the private physicians of Georgia have treated approximately 60% of the total syphilis cases reported each year. During this same period of time, better than 99% of all infectious (primary and secondary) syphilis cases have been interviewed for

contacts and suspects by the trained interviewers of the Georgia Department of Public Health. For the past six years, no private physician has refused the Department permission to interview a reported primary or secondary syphilis case. Most of the syphilis cases treated by the private physicians of Georgia have been treated without charge to the patient—particularly in areas where there is no Public Health Service physician or clinic where diagnosis and treatment is readily available (drugs have been furnished by the Department).

### A Partnership

During 1965, Health Investigators of the Georgia Department of Public Health visited 94% of the private practitioners in Georgia in the continued effort to make VD control in the State a partnership between Public Health and the private practitioner.

The alarming increase in primary and secondary syphilis in the nation and in Georgia since 1957 is primarily attributable to the drastic reduction in Federal appropriations for VD control in fiscal year 1954 (a reduction from approximately ten million dollars a year to 2.3 million dollars a year). Federal appropriations for VD control have been restored gradually since 1954 to the present figure of approximately ten million dollars. Due to the increased costs of program operations, this amount is inadequate to give the states sufficient Federal Project Grant-in-Aid funds to operate at maximum efficiency.

A long-range view of VD control in Georgia gives a much brighter picture—primary and secondary syphilis cases reported in the peak year (1947) was 3,831 compared to 1,067 cases in 1965; in 1950, 1,385 cases of congenital syphilis were reported as compared with 40 cases reported in 1965; in 1946, 16,101 total syphilis cases were reported compared with 2,479 cases reported in 1965; in 1946, 17,228 cases of gonorrhea were reported as compared with 10,969 cases reported in 1965; in 1947, 1,184 cases of chancroid were reported as compared with 238 cases reported in 1965; in 1947, 332 cases of Granuloma Inguinale were reported as compared with 25

cases reported in 1965; in 1945, 699 cases of Lymphogranuloma Venereum were reported as compared with 28 cases reported in 1965.

The Georgia Department of Public Health believes that it enjoys a better partnership with its private

physicians in the control of the venereal diseases than does any other state. With this continued relationship and with adequate VD control funds, the Department believes that the venereal diseases can be brought under control within the foreseeable future.

## The Effects of Heat Upon the Human Body

IT MUST BE alarming to physicians each year at this season to learn of the sudden deaths, attributed to the effects of heat, of a number of so-called healthy athletes. It is even more alarming when one realizes that to a large degree these deaths are preventable. It behooves those physicians who are functioning in an advisory capacity, or as team physicians, to enlighten those in charge of athletes in this environment to adhere as closely as possible to the basic laws of physiology. The body of an athlete can be conditioned, but the extent of the conditioning must be held within certain physiological limitations regardless of his athletic ability. A well-timed break, the serving of iced salt water, ice cubes, cold drinks etc., will require only a few minutes and could very well prevent the death of some young athlete. The wearing of shorts and cool shirts when contact is not anticipated may add much to the morale of the squad.

### Varied Effects

The varied effects of heat upon the human body may range all the way from merely an unpleasant sensation at one extreme, to death at the other. The human body under normal environmental conditions possesses a fairly efficient thermostatic mechanism for maintaining a constant body temperature against extreme environmental changes for short periods. In our present "way of life," with increased mechanization, labor saving devices, shorter work days and weeks, better housing and working conditions, air conditioning and the trend of our dress to more sparse and comfortable clothes, one is rarely confronted with serious problems in the area of thermostatic control. A good balance is usually maintained between the heat producing and heat dissipating factors. On the other hand, the situation of extreme and prolonged muscular exertion in a hot and humid environment poses a serious threat to one's health and life. Each year deaths are reported rising out of

this combination of factors. These are preventable deaths. It is therefore timely that the following is presented for your consideration.

### In the South

The football season in our section of the United States is a hot weather sport. The majority of our pre-season practice sessions and the majority of our scheduled games take place during the hot weather. According to the United States weather bureau, the average temperature for September in Atlanta is 74.4 degrees Fahrenheit, for the month of October it is 63.4 degrees Fahrenheit. The mean humidity for September is 70.6% and for the month of October it is 68.3%.

Heat production in the human body is largely produced by oxidative processes in the skeletal muscles. Strenuous muscular exercise increases the body metabolic rate ten to fifteen times. Body temperatures above 105° have been reported in normal athletes after indulgence in strenuous exercise. The rise in the body temperature parallels the intensity and duration of the muscular exertion. The increased heat is a byproduct of muscular activity. Under normal conditions the body may rid itself of this heat and no ill effects occur.

Heat loss from the body is brought about by the following mechanisms:

- I *Radiation:* (to surrounding walls and objects) This method accounts for 50% of the body's heat loss.
- II *Convection:* (to surrounding air) This method accounts for 25% of heat loss.
- III *Evaporation:* (from the skin and lungs) This method accounts for 25% of our heat loss. (skin 16% and lungs 9%)
- IV *Excreta:* (urine and feces) This method is trivial.



Despite the sum of these methods, the body has been estimated to be only approximately 20% efficient in the dissipation of heat from the body.

### The Effects

The first effect of an accumulation of increased body heat is to cause a dilatation of the peripheral blood vessels and increased blood flow to the skin. This method alone will cool our body if the outside temperature does not exceed 86 degrees Fahrenheit. When the temperature exceeds this value, sweating occurs. The evaporation of this sweat on the skin causes further cooling, provided we are wearing a minimum of the proper type clothing and the humidity of the air is not too high. One may then easily visualize that if the environment is hot and the humidity is high, less radiation and evaporation occurs and our thermostatic efficiency may be decreased in the vicinity of 50%. Add to this situation extreme muscular exercise and a climate is created which the body is unable to handle, and then one suffers the ill effects of heat.

### Permanent Damage Could Occur

When the human body is denied sufficient water and salt in the presence of muscular exercise in high temperatures, certain ill effects have been observed similar to those which occur in high body temperature produced by infectious diseases. If these processes are repetitive, one could conceivably suffer permanent and irreparable body damage, so one should approach the problem of water and salt intake intelligently. The water and salt requirements are directly related to those lost through muscular exertion and sweating. This amount of water may amount to several gallons or as much as eight to ten pounds of body weight, plus several grams of salt, during a given hot afternoon. It is therefore doubtful whether the ill-conceived term "water discipline" and its related practices has a rightful place in modern day training methods. Certainly the drinking of large

amounts of water during strenuous exercises is to be avoided, yet small amounts of water or ice cubes could do no harm and no doubt prevents accumulative effects of dehydration and, least of all, improves morale.

The best insurance against any of these undesirable heat effects is prevention. It therefore behooves those who are responsible for the training and participation of athletes in football during hot and humid weather conditions, to exert good judgement in controlling these conditions as much as possible. One cannot change the weather, but we can schedule practice sessions during the cooler part of the day and require the least amount of clothing and protective gear possible, schedule rest and fluid breaks during practice sessions, require the drinking of ice salt water and/or the consumption of salt tablets.

### Performance May Be Affected

The performance and efficiency of the athlete on certain days may not be due to ineptness or lack of desire on his part; he may be suffering from some ill effects of heat! The coach will probably be the last one to know from the individual about his symptoms. In his zeal to make good, and in order not to jeopardize his chances of making the team, he may not be aware of, or admit certain early symptoms. What then are some of these symptoms which one should be on the alert to detect in the athlete, or should recognize if reported? They may be vertigo, headache, weakness, visual disturbance, nausea, vomiting, either flushing or pallor of the skin, either a hot dry skin or profuse perspiration, mental sluggishness, stumbling or unsteady gait, fainting, complete collapse and unconsciousness. In any event, if one is in doubt, have the individual drop out a few minutes for observation and interrogation by the trainer or team physician.

*Lamont Henry, M.D.  
1293 Peachtree Street, N.E.  
Atlanta, Georgia 30309*

## MAG SPONSORS GEORGIA RURAL HEALTH CONFERENCE

The Medical Association of Georgia will sponsor Georgia's first Rural Health Conference on October 22-23, 1965, at the Rock Eagle State 4-H Club Center, Eatonton, Georgia. The purpose of the Conference is to impart health care information to rural leaders. Representatives of the Georgia Farm Bureau, Agricultural Extension Service, Home Demonstration Councils and other adult lay leaders are being invited to attend this two-day meeting.

Keynoting the program is Mrs. W. Bruce Schaefer,

Director, Georgia State Department of Family and Children's Services. Dr. Addison Duval, Director of the Georgia Department of Health, Mental Health Division, will also address the Conference on the subject "Development of Comprehensive Mental Health Programs."

Other topics scheduled for the Conference include Immunization, Dental Care, Nutrition and Medical Quackery. This meeting is a joint effort by the Georgia Farm Bureau and the MAG in the interests of improved rural health care in Georgia.



## THE PHEASANT RUN CONFERENCE

**A**LTHOUGH the above title at first glance might give the impression of taking things easy and shooting pheasants, this was really a working Conference of State Medical Society Presidents, Presidents-Elect, and Immediate Past Presidents.

Most of us had spent the preceding day and a half in Chicago at the American Medical Association Public Relations Institute. We arrived at Pheasant Run Lodge—a really delightful place—about 4:30 P.M. on Friday, August 20. We had come the 40-plus miles west from Chicago by special bus.

The conference got right down to business at 5:00 P.M., discussing primarily problems of communications until 6:30 P.M.

### "Medicare"

All of Saturday morning was spent in discussion of "Medicare" and other proposed Federal medical programs. Special guests were Mr. Arthur Hess of the Social Security Administration and Dr. Phil Lee of California, the very recently appointed Deputy Assistant Secretary of Health, whose work will be with the "Medicare Program." Dr. Lee is a personable young internist who had been in private practice in Palo Alto. I got the impression that he hoped to return to private practice in the not too distant future. Both of these gentlemen made short talks, after which they were bombarded with numerous questions.

Among other things, Mr. Hess stated that the Department of HEW was concerned with serving people—widows, children and retired old people. He emphasized the need for medical advice, stating that they would "bend over backward" to get it. He further stated that implementation of the program would be at the state level. According to him, HEW has never set or questioned a fee, but is concerned with quality standards.

Dr. Phil Lee stated that in the five days since taking over his position he had been confronted and impressed by the array of opportunities and problems. It is his responsibility to advise the Secretary on all matters relating to Health and Medical Care. He further stated that among his objectives would be: An effort to make the free enterprise system work better, and secondly, to maintain high ethical standards and a high sense of responsibility.

The AMA has been assured that before the final

adoption of the regulations, its "Task Force" will be given the opportunity to review the regulations and make suggestions.

It would appear from the comments of these gentlemen that it is their desire to make the "Medicare Program" less unpalatable to the profession to the extent that it can be done. SO MAY IT BE. We must remember, however, that both these people owe their appointments to a left wing administration, and it is to be wondered how much they may be able and willing to do to make these programs less unpalatable to us.

Many of you will remember Mr. Stetler, formerly head of the AMA Legal Department, but now Chief Counsel for the American Pharmaceutical Manufacturers Association. Mr. Stetler discussed the matter of non-participation. He stated that the Sherman Act would apply to any concerted action to refuse to deal, but that while there was a substantial agreement that it is the prerogative of an individual to refuse to deal, some factors might implicate the individual physician should he be the instrument to prevent the receipt of proper care. He further stated that the right to hospital privileges was not a vested right, that it would be reasonable to require agreement to participate as a condition of privileges.

Two other special and interesting guests were AMA President James Z. Appel and President-Elect Charles L. Hudson.

Following Saturday lunch, there was another two-hour conference concerned chiefly with the recapitulating of material previously discussed.

President-Elect Walter Brown and I found this to be a most interesting and informative Conference. Plans are for it to continue, probably on a semi-annual basis.

Since the conclusion of the Presidents' Conference, notice has been received that the AMA will hold a National Conference on "Medicare" in Chicago on October 16-17. We will have representatives to attend this meeting and I am sure you will be hearing more about it later.

George H. Alexander, M.D.  
President, Medical Association of Georgia





## VERTEBRAL-BASILAR INSUFFICIENCY CAUSED BY OCCLUSIVE DISEASES OF THE SUBCLAVIAN ARTERY THE "SUBCLAVIAN STEAL SYNDROME"

W. Brem Mayer, Jr., M.D.,\* *Atlanta*

**T**HAT SYMPTOMS of cerebral ischemia could be produced by reversal of blood flow in one vertebral artery was first demonstrated in 1961. The vertebral arteries arise from the subclavian arteries, course through the cervical transverse processes into the foramen magnum, over the ventral surface of the medulla and, at the pontomedullary junction, join to form the basilar artery. This is the only point in the body that two arteries join to form a single artery. This unique anatomic feature makes reversal of flow in the vertebral artery possible.

### Obstruction

Obstruction of the proximal portion of one subclavian artery lowers the pressure in the homolateral vertebral artery. Blood supply from the contralateral vertebral artery may produce a pressure at the origin of the basilar artery greater than that at the mouth of the compromised vertebral artery, with retrograde flow down that vertebral, away from the basilar artery. This can result in ischemia in the distribution of the basilar artery. Experimental work in both humans and animals has shown that such a stenosis in the subclavian artery can significantly reduce blood flow in the basilar artery. In the dog, it is only necessary to reduce the pressure beyond the obstruction by 15% to produce complete reversal of flow in the homolateral vertebral artery.

### Reduction of Blood Flow

The reduction of blood flow in the basilar artery may produce transient symptoms of ischemia that are usually, but not always, referable to the basilar circulation. The most common symptoms are tran-

sient blindness, diplopia, vertigo, dysarthria, tinnitus, monoparesis, hemiparesis or "drop attacks." In the "subclavian steal" syndrome these symptoms may be precipitated by exercising the arm on the side of the obstructed subclavian. The original cases emphasized the role played by exercise of the ischemic arm. More recent reports indicate that this is the exception rather than the rule and that, most often, there is nothing in the history that helps to differentiate vertebral-basilar insufficiency secondary to subclavian obstruction from the more usual forms.

Significant obstruction of the subclavian artery is always associated with a difference in the blood pressure in the two arms. The reduced pressure on the obstructed side may be readily recognizable by palpating the two radial arteries. However, one should take the blood pressure in both arms since a systolic difference of 20 millimeters of mercury and a diastolic difference of 10 millimeters of mercury may be clinically significant. Usually the difference is greater than this. A systolic bruit in the supraclavicular fossa is frequently heard and there is often evidence of arterial disease elsewhere.

### Arteriogram Visualized

An arteriogram visualizing the aortic arch and all of the major cervical vessels may confirm the obstruction in the subclavian artery. The use of serial radiography frequently demonstrates the reversal of flow in the vertebral artery.

The treatment of choice is surgical removal of the obstruction. This can be done by endarterectomy or a by-pass graft. Both of these procedures necessitate entering the thorax. In patients whose general medical condition would make a major surgical procedure hazardous, the vertebral arising from the diseased subclavian artery can be ligated near its origin. This will stop the reversal of flow. Because retrograde thrombus formation may occur after vertebral ligation

From the Neurology Section, Department of Internal Medicine, Emory University School of Medicine and Grady Memorial Hospital, Atlanta.

Supported by Grant 2 TI NB 5071-10, United States Public Health Service.

\*Second year resident, Neurology, Grady Memorial Hospital.

## HEART PAGE / Continued

tion, it is advised that these patients be anticoagulated.

A surgical remediable form of transient cerebral ischemia is discussed. The signs and symptoms of cerebral ischemia are frequently the same in both extracranial and intracranial occlusive vascular disease. Asymmetry of blood pressure in the upper extremities in association with these signs and symptoms should suggest obstruction of the subclavian

artery and is an indication for further diagnostic studies such as selective cerebral arteriography.

### SELECTED BIBLIOGRAPHY

1. Heyman, A., et al.: Cerebral Ischemia; *Arch. of Neurology* 10:581, 1964.
2. Reivich, M., et al.: Reversal of Blood Flow Through Vertebral Artery and Its Effect on Cerebral Circulation; *New Eng. J. Med.* 265:878, 1961.
3. Toole, James F.: Reversed Vertebral Artery Flow; *Lancet* 1:872, 1964.

*Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.*

## 1965 CALENDAR OF MEETINGS

### State

October 27-30—Second Annual Institute on Group Behavior and Group Leadership, sponsored by the Department of Psychiatry, Emory University School of Medicine, Holiday Inn, Callaway Gardens, Pine Mountain, Ga.

For 1965: Postgraduate Courses sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.

October 14-15—Whitfield County Medical Symposium, Dalton, Ga.

September 29-December 15—Psychosomatic Medicine (12 weekly evening sessions)

November 15-19—General Practice Review:

November 15—OB-GYN

November 16—Internal Medicine

November 17—Endocrinology

November 18—Cardiology (a.m.)  
The Eye (p.m.)

November 19—Pediatrics

December 1-2—Fractures

December 7-May 12—Georgia Circuit Course (six sessions one day each month at six centers in Georgia)

November 11-13—Postgraduate Course "What's New in Surgery," sponsored by the Department of Surgery, Emory University School of Medicine, Grady Memorial Hospital Auditorium, Atlanta.

November 15-17—Postgraduate Conference in Gynecologic Cancer sponsored by the Department of OB-GYN of Emory University School of Medicine in association with the Georgia State Obstetrical and Gynecological Society, Grady Memorial Hospital Auditorium, Atlanta.

May 8-10, 1966—112th Annual Session of the Medical Association of Georgia, Columbus.

### Regional

October 21-29—American Occupational Therapy Association, Americana Hotel, Bal Harbour, Fla.

October 24-27—American College of Gastroenterology, Americana Hotel, Bal Harbour, Fla.

October 29-30—Symposium on Common Problems in General Practice—Office Procedures, sponsored by the Mound Park Hospital Foundation, Florida Academy of General Practice (16th Annual Scientific Assembly), St. Petersburg, Fla.

November 1-4—Fifty-Ninth Annual Meeting of the Southern Medical Association, Houston, Texas.

November 1-4—Annual Meeting of the Section on Otolaryngology of the Southern Medical Association, Houston, Texas.

November 3-5—American Society of Tropical Medicine and Hygiene, Jung Hotel, New Orleans, La.

November 3-5—Tennessee Academy of General Practice, 17th Annual Scientific Assembly, Gatlinburg Auditorium, Gatlinburg, Tenn.

November 11-13—Symposium on "Cerebral Palsy: Modern Concepts—Allied Disorders, Rehabilitation," sponsored by the Mound Park Hospital Foundation, Department of Medical Education of the Mound Park Hospital, St. Petersburg, Fla.

November 17-20—International Conference on Hyperbaric Medicine (3rd), Duke University Medical Center, Durham, N. C.

December 7-9—Southern Surgical Association, Homestead, Hot Springs, Va.

January 13-15, 1966—American College of Surgeons Sectional Meeting, Bal Harbour, Fla.

January 31-February 2, 1966—American College of Surgeons Sectional Meeting, Houston, Tex.

February 28-March 4, 1966—Seminar in Obstetrics and Gynecology. Cruise to Nassau and Freeport in the Bahamas, *S.S. Ariadne*. Sailing from Ft. Lauderdale, Fla. Presented by the Dept. of Obstetrics and Gynecology, College of Medicine, University of Florida. Approved by Florida State Board of Health, Florida Medical Association, and Florida Academy of General Practice.

### National

September 15, 1965-June 15, 1966—A nine month tutorial program in Cardiology offered by the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

November 15-18—Interstate Postgraduate Association of North America, Cleveland Assembly, Cleveland, Ohio.

November 19-22—1965 Annual Meeting of the National Society for Crippled Children and Adults (The Easter Seal Society), Palmer House, Chicago.

November 28-December 1—American Medical Association (Clinical Convention), Philadelphia.





### "BIRTH CONTROL DECISION"

John L. Moore, Jr., *Atlanta*

ON June 7, 1965, the Supreme Court of the United States handed down the long-awaited and very important decision concerning the Connecticut birth control laws. One of the Connecticut statutes prohibited the giving of information, instructions, and medical advice on birth control. The other prohibited any person from using any drug, medicinal article, or instrument for the purpose of preventing conception.

#### Connecticut Laws Unconstitutional

The Supreme Court of the United States reversed the decision of the Court of Errors of Connecticut which had upheld the validity of the statutes. In setting aside the Connecticut birth control laws, the Supreme Court divided sharply. Seven justices voted to reverse the Connecticut decision while two voted to affirm. Six different opinions were entered. The majority opinion was written by Mr. Justice Douglas. Mr. Justice Harlan wrote a special concurring opinion. Mr. Justice Goldberg, joined by the Chief Justice and Mr. Justice Brennan, wrote another concurring opinion. Mr. Justice White wrote a third concurring opinion. Mr. Justice Black wrote one dissenting opinion, and Mr. Justice Stewart wrote the other.

All nine justices carefully said that they disliked the Connecticut laws. Mr. Justice Stewart, in his dissenting opinion, said:

"I think this is an uncommonly silly law."

He also said:

"As a philosophical matter, I believe the use of contraceptives in the relationship of marriage should be left to personal and private choice, based upon each individual's moral, ethical, and religious beliefs."

#### Privacy in Marriage

The seven justices voting for reversal all, in one way or the other, recognized the "right of privacy in marriage."

The disagreement among the justices arises from highly technical discussions of relations of States to

Federal Government and the meaning of the amendments to the Constitution of the United States. The scope of this article does not allow for discussion of these differences.

The point which will certainly interest the medical doctor is that this decision undoubtedly affects his married patients. It also has important implications on the advice and treatment a medical doctor may give to his married patients despite restrictive State laws.

The majority opinion, for example, in criticizing the Connecticut laws, stated:

"This law, however, operates directly on an intimate relation of husband and wife and their physician's role in one aspect of that relation."

Mr. Justice Goldberg made the interesting point that, if a state law could prevent the use of contraceptives, the same reasoning would allow a state law to require compulsory birth control. This seemed offensive to him.

#### Other Implications

In his dissenting opinion, Mr. Justice Stewart wrote an interesting sentence at the end of one footnote:

"I suppose, however, that even after today a State can constitutionally still punish at least some offenses which are not committed in public."

To what is Mr. Justice Stewart referring? Mr. Justice Goldberg's opinion, as well as the other opinions for reversal, expressly limited the opinion to relations between husband and wife. All emphasize that States retain the right to prohibit adultery, homosexuality, and other extra-marital sexual relations.

Once the "right of privacy in marriage" is recognized, it is hard to see how any State could apply its statutes prohibiting unnatural sexual relations between husband and wife. Further, it would seem to the writer that the same "right of privacy in mar-

riage" might well protect husband, wife, and treating medical doctors if, instead of using drugs, medicinal articles, or instruments for the purpose of preventing conception, they use sterilization procedures such as vasectomy or salpingectomy.

Did Mr. Justice Stewart, in the sentence quoted from his footnote, however, fear that the majority opinion might protect other "private relations"? Is he suggesting that he sees implications in the majority opinion that States may not continue to prohibit

and punish fornication, adultery, and homosexuality provided the acts are in private between consenting adults? This seems unlikely. The writer of this article does not see anything in the majority opinions which would lead to such implications.

However, it will be interesting to follow the effect of the very important reported decision. It is called *Griswold v. Connecticut*.

*Suite 1220*

*C & S Bank Building*

---

*Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to the Medical Association of Georgia.*

There were 43,999 medical articles on heart drugs published between 1931 and 1959.

## **WHOLESALE PRICE INDEX FOR PHARMACEUTICALS DECLINES FOR SIXTH STRAIGHT YEAR**

The Wholesale Price Index for Ethical Pharmaceuticals has declined for the sixth straight year.

The index fell during 1964 from a level of 86.2 to an all-time low of 86.0 (1949 equals 100.0). This index, which measures price changes annually, has been prepared by Dr. John M. Firestone, of the City College of the City University of New York.

Dr. Austin Smith, President of the Pharmaceutical Manufacturers Association (PMA), said the drop in the index parallels that in the U. S. Bureau of Labor Statistics Wholesale Price Index for "Ethical Pharmaceutical Preparations" since its revision in 1961. The Government Index declined from 100.1 in December 1960, to 94.8 last December, while the industry index declined from 92.4 to 86.0.

Each year this index shows whether the wholesale prices for the items included in the index are higher or lower than the preceding year since 1949. The index number does not indicate whether wholesale drug prices are "high" or "low." This is a characteristic of all price indexes whose list of priced products does not remain static.

The ethical pharmaceutical index has declined in ten of the years since 1949, risen in three years and remained unchanged two years. Prices used for the purpose of constructing the index are those published in the "Red Book," a standard drugstore catalog. They are the manufacturer's highest offering prices for wholesale sale. Actual prices paid by retailers frequently are less than "Red Book" published prices.

Dr. Smith said, "The significance of this index to the public is that wholesale drug price trends are exceedingly favorable when viewed against the price records for all commodities in recent years. While all wholesale prices have risen more than 20%, wholesale drug prices have declined 14%.

## **GEORGIA HEART ASSOCIATION TO PRESENT EDUCATIONAL TELEVISION PROGRAMS FOR PHYSICIANS**

A series of educational programs for physicians, on heart disease, will be presented on Georgia's educational television network beginning in October.

### **Twelve Programs Scheduled**

Under auspices of the Georgia Heart Association, 12 monthly, professional level programs will be telecast by the ETV Network on such cardiovascular subjects as Peripheral Vascular Disease, Angina Pectoris, Acute Myocardial Infarction, etc. This series will be expanded in the near future to include programs of interest to the lay public.

The programs will appear on the first Monday and Tuesday of each month, after completion of regular programming. On the evenings of the GHA sponsored programs, the ETV network will be reactivated at 10:30 for the special hour-long telecasts.

Initial programs in this series are being made available by Dale Groom, M.D., Medical College of South Carolina, who produced them at the South Carolina Educational Television Center through a grant from Merck, Sharp & Dohme's Postgraduate Program.

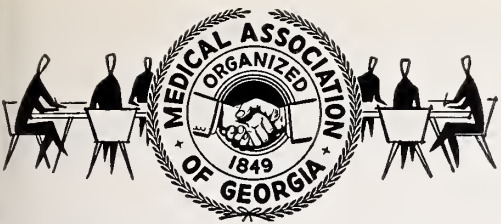
Many Georgia physicians are already within range of one of the four ETV transmitters and all will be when the state completes the entire network in the fall of 1966.

### **Program Dates**

The program dates and subjects are: October 4-5, Acute Myocardial Infarction; November 1-2, Angina Pectoris; December 6-7, Mechanisms of Congestive Heart Failure; January 3-4, Treatment of Congestive Heart Failure; February 7-8, Peripheral Vascular Disease; and March 7-8, Treatment of Hypertension.

An announcement of an additional six month's programs will be made soon.





# THE ASSOCIATION

## DEATHS

ALLEN H. BUNCE, 75, of Atlanta, died July 30, 1965.

Dr. Bunce was a native of Bulloch County. He received his A.B. degree at the University of Georgia and was a member of Phi Beta Kappa scholastic fraternity. He was graduated from the Emory University School of Medicine.

Dr. Bunce practiced medicine in Georgia for more than 52 years. He had been President of the Medical Association of Georgia and had been President and trustee of the United States Pharmacopeial Convention.

In World War I, he was a captain in the medical corps in France, and was decorated by the French government.

In Dr. Bunce's family there are ten doctors, three druggists, and two nurses.

Dr. Bunce was a member of the First Methodist Church of Atlanta.

Survivors are his widow, the former Isabella Arnold; a sister, Mrs. Turner E. Smith, Atlanta, and brothers, Dan M. Bunce, Quitman, and J. Arthur Bunce, Statesboro.

GIBSON KELLY CORNWELL, 62, of Fitzgerald, died August 4, 1965, at Phoebe Putney Hospital in Albany after several weeks' illness.

Dr. Cornwell moved to Fitzgerald from Milledgeville 22 years ago. He was a member of Ben Hill-Irwin County Medical Society, Medical Association of Georgia, American Medical Association, Fitzgerald Elks Club, Fitzgerald Country Club, First Baptist Church, and served as Health Officer of Ben Hill County for a number of years.

Survivors include two daughters, Mrs. W. C. Leanard of Fayetteville, N. C. and Miss Kelly Jo Cornwell of Fitzgerald; three brothers, Dr. Joseph D. Cornwell, Jr., Conyers, and Lane Cornwell and James Cornwell, both of Atlanta, and a sister, Mrs. Josephene Cornwell Orr of Atlanta.

ALLEN ISAAC ROBBINS, 46, widely known Homerville physician, died unexpectedly in Clinch Memorial Hospital July 31, 1965, following a heart attack.

A native of Conway, Arkansas, he served two years in the U. S. Navy before moving to Homerville about 18 years ago for the practice of medicine. In recent years, his offices, known as Robbins Clinic, have been located on Plant Avenue.

Since being in Homerville he had always been a very active member and supporter of the Baptist church. He was a deacon, having served as chairman a number of years. He was a member of the church choir, and constantly served on various church committees.

He was president of the Lake Verne Hunting & Fishing Club; a past president of the Lions Club; a Mason; member of the City Planning Commission; medical advisor to the local Selective Service Board since 1948; member of the Clinch County Board of Health; member of the South Georgia Medical Society, the Medical

Association of Georgia, the American Medical Association, and a charter member of the American Academy of General Practice.

Dr. Robbins was a graduate of Hendrix College, Conway, Arkansas. He received his medical degree from the University of Arkansas in 1944. He served his internship in San Antonio, Texas.

Survivors include his wife, Mrs. Mary Ann Pittard Robbins; two sons, Allen I. Robbins, Jr. and Charles W. Robbins, and two daughters, Miss Bebe Robbins and Miss Jan Robbins, all of Homerville; four brothers, Wellington F. Robbins and Dr. Joe S. Robbins of Conway, Ark., Stanley Robbins of West Memphis, Tenn., and Col. Frank Robbins of Birmingham, Ala.; and a number of nieces and nephews.

## PERSONALS

### Second District

T. GRAY FOUNTAIN and O. GREY RAWLS, Albany, announce the association of J. WILBUR OGLESBY in the practice of thoracic and cardiovascular surgery. Their offices are located at 910 North Jefferson Street.

### Third District

R. A. COLLINS, Americus, presented an address on the John Birch Society at the weekly luncheon meeting of the local Lions Club meeting July 26, 1965.

VILDA SHUMAN of Waycross was recently elected President of Pilot Club International at the 44th Annual Convention of the organization held in Dallas, Texas. Active in medical, civic, religious and service organizations in Waycross, Dr. Shuman has been a Pilot since 1948. She was the 1955 winner of the Waycross Pilot Club's Past President's Cup, for outstanding community and club service and was the joint winner in 1958. She has served the Pilot Club of Waycross as President, First Vice President (twice), Director (four years) and Chairman of the True Course Ever, International Relations, Coordinating (2 years) Pilot Information, Anchor Club and Public Affairs Committees.

### Fifth District

DAVID HENRY POER, Atlanta, has recently been elected to the staff of Memorial Hospital, Waycross, as a consultant. A general surgeon, Dr. Poer also serves in a consultory position on the staff of the Surgeon General of the U. S. Army.

### Sixth District

JOHN PAUL JONES, Macon, has recently been elected Chairman of the Board of Governors of Stratford Academy, Macon, for the 1965-66 school year.

L. A. ERBELE of Macon was named pathologist for the Houston County Hospital at a meeting of the Houston Hospital Authority July 5, 1965. Dr. Erbele will

## THE ASSOCIATION / Continued

assume direction of all pathology services and laboratory supervision for the hospital.

### Eighth District

Waycross ophthalmologist, S. W. CLARK, JR., was presented the Homer L. Baker Memorial Plaque at a special ceremony conducted in July by the Waycross Lions Club. The citation, offered annually in honor of the late Dr. Barker of Carrollton, who served as a director of Lions International, is designed particularly to recognize ophthalmologists, optometrists, and opticians who contribute their services to the Georgia Lions Lighthouse, the statewide organization operated by the Lions.

A native of Hoboken, Georgia, DAVID JACOBS, has recently opened offices in Waycross for the general practice of medicine, and has been elected to the courtesy staff of Memorial Hospital. Dr. Jacob's office will

be located in the new medical complex under construction on Alice Street.

HOWARD S. MacGREGOR has recently become associated with Y. F. CARTER and GRADY WILLIAMS at the Doctors Building adjacent to Berrien County Hospital in Nashville.

MACK SIMMONS, Brunswick, was elected Chief of the Medical Staff of the Brunswick Nursing and Convalescent Center, Inc. at a meeting of the staff August 2, 1965. WILLIAM F. AUSTIN was elected Assistant Chief of Staff and ROBERT CRIGHTON was elected secretary.

JOHN LEE ANDERSON, JR. began the practice of medicine September 1, 1965, in partnership with CHARLES JORDAN in a new office building on Osborne Street, St. Mary's.

JOE C. STUBBS, internist, has opened an office at 2200 North Patterson Street in Valdosta.

## NEW '66 DUES STATEMENT TO "PASS THE HAT" FOR GaMPAC

MAG Annual Dues Statements, soon to be shipped in bulk to County Medical Society Secretaries, will have a new look for the 1966 year.

The MAG House of Delegates in May, approved a plan to permit the voluntary collection of GaMPAC and AMPAC dues at the same time and in the same manner as dues are collected for the various echelons of medical organization. In so doing it followed a recommendation previously adopted by the AMA House of Delegates at its Clinical Convention in 1964.

As a result, an additional line has been added to the statement to facilitate the lump sum payment of dues to County Medical Societies, MAG, AMA, GaMPAC-AMPAC, and in most instances to District Medical Societies.

### Member of Both

GaMPAC dues are \$25 per year for physicians. Of this amount \$10 is forwarded to AMPAC and the payee thus becomes a member of both, but separate, organizations. Payment of GaMPAC-AMPAC dues is completely voluntary and will be so indicated on the statement. Inasmuch as these dues will support political action they are non-deductible for tax purposes and this also will be noted on the statement.

The medical society for the State of Pennsylvania, which pioneered this joint billing concept two years ago, experienced a 78% membership participation in its political action committee in those counties which added this item to their regular billing. By contrast, in those counties that did not, they experienced only a 4% membership participation.

## TB ASSOCIATION MAKES PULMONARY STUDY AWARD

Awarding of a \$7,000 Christmas Seal supported fellowship for a year's specialized training in pulmonary diseases has been announced by Dr. Lester Rumble, Jr., Atlanta, chairman of the Georgia Tuberculosis Association's Medical Education and Research Committee. Recipient is Dr. Robert L. Galphin, Jr., 2153 Tanglewood Road, Decatur, who completed his medical residency at Emory University Hospital in June. Training under the program began July 1.

The medical education fellowship includes \$4,500 from the American Thoracic Society, medical wing of the National TB Association, \$1,000 from the Georgia Tuberculosis Association and \$1,500 contributed by local tuberculosis associations throughout the state. All TB Associations activities are supported by the annual Christmas Seal Campaign.

### Program Two Years Old

Initiated two years ago by the Board of Directors of the state TB Association, this pilot project in medical education is designed to improve services for pulmonary disease care through the training of young physicians. It provides a minimum of \$5,000 annually for the full or partial support of one or more trainees or scholarship's for physicians to attend specialized courses in pulmonary diseases not available within the state. Dr. Galphin is the first candidate selected for a traineeship.

## NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

Breckenridge, Homer E., Jr. Hospital Circle  
Active—Decatur-Seminole Donalsonville, Georgia 31745

Geiger, C. Leonard Hall County Hospital  
Active—Hall Gainesville, Georgia 30501

Gray, W. E., Jr.  
Active—Emanuel

Lee, A. Eugene  
Active—Stephens

116 Church St.  
Swainsboro, Georgia 30401

Box 394  
Buena Vista, Georgia 31803



## SUMMARY OF RECENT MAG COUNCIL AND EXECUTIVE COMMITTEE ACTIONS

(The full minutes from which these summaries have been abstracted are available to any MAG member upon request to the Journal.)

### Executive Committee of Council / July 11, 1965

*Office of Dependents Medical Reply to Request for Publication of Fee Schedule*—Executive Committee voted to notify the members by inserting a notice in *JMAG* that maximum allowances contained in the Medicare Manual are available from MAG Headquarters if the member desires this information.

*Appointments*—The Executive Committee took the following action:

(a) *Talmadge Hospital Liaison Committee*—Agreed to write the following regarding appointments to this committee:

Richmond County Medical Society—to appoint someone to replace Charles W. Hock, Augusta, whose term expires 1965.

Medical College of Georgia—to appoint two representatives to replace Harry B. O'Rear and Rufus Payne, whose terms expire 1964 and 1965.

1st, 2nd, 3rd, 5th, 6th, 8th and 9th Districts—to appoint representatives.

Each district society is to name their representative to this committee and the Chairman, Dr. Dillinger, is to be informed of the appointments.

(b) *Hospital Advisory Council*—At the Governor's request, and in compliance with the Act approved March 31, 1965, which amends the Georgia law of 1964 relative to appointment of members to the Hospital Advisory Council, the Executive Committee approved the nomination of three members for consideration of one by the Governor, as follows: Neal F. Yeomans, Waycross; Rafe Banks, Jr., Gainesville; and A. B. Congers, Columbus. On motion (Andrews-Jennings) it was voted to recommend the names of the above three nominees to the Governor.

(c) *MAG Medical Ethics Committee Chairman*—On motion (Brown-Eldridge) it was voted to appoint Peter Hydrick, East Point, Chairman of the MAG Medical Ethics Committee, with Donald Rooney, Marietta, Robert Wells, Atlanta, and Thomas W. Goodwin, Augusta, as members.

(d) *Liaison Member With State Mental Health Division*—The Executive Committee voted to ask the Mental Health Subcommittee Chairman to act as liaison member with the State Mental Health Division or a member of the Mental Health Subcommittee designated by the chairman. It was asked that the former liaison member, Dr. Dillinger, be informed of this action.

(e) *Constitution and Bylaws Board*—After discussion by President Alexander, on motion (Brown-McDaniel) it was voted to appoint Linton H. Bishop, Atlanta, to fill the unexpired term of Dr. Alexander.

(f) *State Advisory Committee on Alcoholism*—At the request of the Governor's office the Executive Committee recommended John Mooney, Statesboro; and Fenwick T. Nichols, Jr., Savannah, for appointment to this committee. The Governor is to choose one of the nominees.

(g) *MAG Subcommittee on Medicine and Religion*—The Executive Committee voted to appoint Robert Quattlebaum, Valdosta, to this committee.

*Headquarters Office Report*—(a) Zip coding of MAG membership plates; (b) School Child Health Subcommittee—Dr. Jack Hughston requested approval for sufficient funds to attend the AMA 10th National Conference on Physicians and Schools, Sept. 22-25, 1965, at Chicago. Dr. Mauldin was requested to contact Dr. Hughston about necessary funds and the possibility of Vice Chairman of the subcommittee, Dr. Ben P. Gilbert attending; (c) Medical Aspects of Sports Conference scheduled for August 5-6, 1965, will need additional funds in addition to those already budgeted. Matter deferred until Council meets in September; (d) Appointment of Dr. M. D. Pittard, Toccoa, and Dr. Virginia McNamara, Atlanta, alternate, to the Georgia Teen-Age Nutrition Council from the School Child Health Subcommittee; (e) Cost to MAG for Southeastern States Hospitality Suite at New York AMA meeting is \$312.16 to be paid from already budgeted funds; (f) Received for information: Letter from MAG attorney to the Joint City-County Board of Tax Assessors regarding the assessment for taxation of MAG property; (g) Motion made to ask MAG President to designate a delegate and alternate to attend, at their own expense, the Michigan State Medical Society Centennial Session Sept. 19-24 in Detroit. Drs. Duncan Shepard and Richard A.

Smith, Atlanta, were suggested; (h) Letter from the President of the Woman's Auxiliary was read which stated that the budgeted funds for 1965 would not be needed; (i) Executive Committee voted to extend an invitation to each of the Southeastern states to send a delegate to the MAG Annual Session each year.

*Annual Session Program*—Dr. Spitzer, Chairman of the Annual Session Board, presented the proposed Annual Session schedule for 1966. After lengthy discussion, on motion (McDaniel-Brown) the suggested format of the program was approved.

It was brought to the attention of the Executive Committee that the dates of May 8, 9 and 10, 1966, might cause some disagreement because May 8 is Mother's Day. Mr. Krueger was asked to investigate the possibility of changing the dates to April 24, 25, and 26, and if these dates have been reserved, to retain the May 8, 9 and 10 time.

*Report of Ad Hoc Legislative Study Committee*—Dr. Frank Walker reported that the Ad Hoc Committee appointed to study the reorganization of the Legislative Board and Subcommittees would like to make the following recommended changes: A Legislative Board consisting of five members; a Subcommittee for National Legislation consisting of three members; and a Subcommittee for State Legislation consisting of three members. The recommended appointments would be as follows:

Legislative Board: J. Frank Walker, Chairman; Harrison Rogers, Vice Chairman; R. H. Randolph, Athens; Frank Holder, Eastman; and John T. Mauldin, Atlanta. The National Legislation Subcommittee: J. Frank Walker, Chairman; R. H. Randolph, and John T. Mauldin; with State Legislation Subcommittee: Harrison Rogers, Chairman; Frank Holder, and John T. Mauldin.

On motion (Andrews-Brown) the Executive Committee voted to approve the legislative reorganization plan as presented.

*Treasurer's Report*—Dr. Atwater reported that no formal report would be given this month due to Miss Franklin's illness. Received for information.

### NEW BUSINESS—

(a) *AMA Public Relations Institute*—There is an AMA PR Institute to be held August 19-20, 1965, Drake Hotel, Chicago, and the Executive Committee voted that the following should attend: MAG President, Chairman of MAG Public Service Board, MAG President-Elect and the Executive Secretary. It was voted to take the President-Elect's expenses out of the President's travel fund for this particular meeting.

(b) *AMA Washington Meeting on Federal Legislation Proposing Regional Complexes for Heart Disease, Cancer and Stroke, July 18, 1965*—Dr. Walker announced that two representatives from MAG membership and Mr. Moffett of MAG Staff would attend the meeting.

(c) *AMA National Congress on Medical Ethics*—The following will attend the Congress on Medical Ethics, October 2-3, 1965, Drake Hotel, Chicago, from MAG: Drs. Alexander, Robert Wells, Thomas Goodwin, Peter Hydrick, Mr. Krueger and Dr. Andrews. Mr. Krueger is to make arrangements and notify AMA.

(d) *Alternate AMA Delegate Expenses*—It was suggested by Dr. Atwater that all of the alternate delegates expenses should be paid. It had been voted in the past to pay all of the alternate delegates expenses when feasible. Therefore, this suggestion is to be referred to the Finance Committee for discussion at the 1966 budget meeting.

### Executive Committee / July 30, 1965

A telephone conference call meeting of the MAG Executive Committee of Council was convened to discuss the action of the State Board of Health, as expressed in the Resolution, with regard to the administration of HR 6675.

The members on the call were: George H. Alexander, Forsyth; J. G. McDaniel, Atlanta; John T. Mauldin, Atlanta; Charles R. Andrews, Jr., Canton; Henry S. Jennings, Gainesville; Walter H. Brown, Savannah; and John S. Atwater, Atlanta. The MAG staff members on the call were: Mr. Milton Krueger and Mrs. Catherine Wooten.

Dr. Alexander called on Dr. Mauldin to discuss the matter which had come to Dr. Mauldin's attention regarding



## SUMMARY OF MINUTES / Continued

the Resolution. Mr. Krueger was asked to read this resolution. Dr. Mauldin stated that in essence, the State Board of Health thought the State Department of Health should administer the entire program with the Department of Family and Children Services certifying the eligibility of the individuals only. The statement in the resolution that the American Medical Association had approved and recommended the principle that the state health agency, where applicable, be designated the administrative agency, had been found in error.

## MANY NEW FEATURES AT AMA CLINICAL CONVENTION

A comprehensive scientific program, a new postgraduate course, and special clinical workshops are some of the features of the American Medical Association's 19th Clinical Convention, November 28-December 1, in Philadelphia.

More than 300 physicians will participate in giving the four-day program of lectures, exhibits, motion pictures, color television, fireside conferences, and breakfast roundtables.

### Outstanding Scientific Program

An outstanding scientific program is designed to hold special interest for the practitioner. Some topics to be covered: ulcerative colitis, gram-negative bacterial infections, a medical-surgical review of cardiovascular surgery, drug therapy in rheumatology, and cancer chemotherapy and preventive surgery.

The practicing physician will be able to participate in one of the convention's new features. Clinical workshops on diabetes, examination of the heart, management of common eye problems, and the solution of selected diagnostic and therapeutic problems will be conducted by outstanding teachers.

After discussion, it was generally agreed that a letter should be written by President Alexander to the Governor in which the Department of Family and Children Services should be complimented for the conduct of the Kerr-Mills program in Georgia since its inception; and to ask the Governor to hold his decision about the designation of the state agency to administer HR 6675 in abeyance until a further estimate of the data and complexities of the law have been investigated. It was requested that a draft of this letter be mailed to each member of the Executive Committee before it is mailed to the Governor.

Also new will be a postgraduate course in cardiovascular therapeutics. It will be offered in addition to the popular course on gynecology and obstetrics begun at the clinical convention last year in Miami.

The annual AMA conference on the Medical Aspects of Sports will be held the first day of the meeting, November 28, in the Benjamin Franklin Hotel. It will be of special interest to high school and college team physicians.

There will be approximately 100 scientific exhibits, and 30 medical motion pictures.

Color television will be presented on the stage of the Civic Center in cooperation with the Hospital of the University of Pennsylvania. The subjects of six programs, to be followed by discussion, are "Lymphocytes, Cellular Immunities and Tissue Transplantation," "Renal Hypertension," "Pulmonary Resection," "Pulmonary Function Studies," "Surgical Aspects of Thyroid Diseases," and "Medical Aspects of Thyroid Diseases."

Twelve fireside conferences will be held Sunday evening, November 28, at the Warwick Hotel. They will be joint sessions of the American College of Chest Physicians and the AMA.

## THE MONTH IN WASHINGTON—SEPTEMBER

Despite the flood of major health measures approved by Congress this year, President Johnson apparently plans to propose more important health legislation next year. Health has been given Number One priority on the "great society" program, it appears.

Johnson has been telling Congressmen to think in terms of even greater strides next year.

To lay the groundwork for new legislation, he has called a White House Conference on Health, November 3-4.

Johnson recently took the occasion of signing two health bills to outline his health goals:

—An increase in the average life expectancy from the present 70 years to 75 years.

—A reduction in infant mortality from the present rate of 25 deaths per 1,000 births to 16 per 1,000.

—Virtual elimination of polio, diphtheria and typhoid fever and an end to tuberculosis, measles and whooping cough.

—A reduction of 20% in deaths from heart disease, cancer and stroke—the so-called "killer diseases" that now account for one-third of all U. S. deaths.

—Elimination of death and disability among children caused by rheumatic fever and rheumatic heart disease.

—Eradication of malaria and cholera from the entire world.

One of these two health bills he signed into law authorizes a three-year, \$280 million extension of the Health Research Facilities Act. It also authorizes three additional Assistant Secretaries of HEW, one for Health and Medical Affairs. A special assistant to the secretary had been the top official for Health and Medical Affairs.

### Bill Extended

The other bill amends the Vaccination Assistance Act and extends it for five years. It authorizes Federal expenditures of \$8 million a year, broadens the program to include measles and any other disease designated by the Surgeon General of the Public Health Service and makes the immunization program a continuing one, rather than "an intensive community vaccination (program) of limited duration." Expenditure of \$45 million during the next five years also is authorized for family health clinics for migratory workers.

Neither the chairman nor the vice chairman of the White House Conference on Health is a physician. However, five of the nine members of the executive committee to plan for the conference are physicians. All were appointed by Johnson.

George Beadle, Ph.D., president of the University of Chicago, will be chairman and Boisfeuillet Jones, former special assistant to the HEW Secretary, vice chairman.



**JOURNAL**  
THE MEDICAL  
SOCIATION

NOVEMBER/1965  
*Georgia*

Q & A.

U.C. MEDICAL CENTER LIBRARY

DEC 2 1965

San Francisco 22,

About MAG's new Group Insurance Plan  
that provides bigger benefits than ever before

... See pages 349 and 372



**the difference between cough and relief**

## **Benylin<sup>®</sup> Expectorant**

Each fluidounce contains: 80 mg. Benadryl<sup>®</sup> (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5 per cent alcohol.

**for relief of coughs due to colds or allergy**

**PRECAUTIONS:** Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers, if used with BENYLIN EXPECTORANT, should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT. **PACKAGING:** Bottles of 4 oz., 16 oz., and 1 gallon.

72165

**PARKE-DAVIS**

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232



# JOURNAL OF THE MEDICAL ASSOCIATION

# Georgia

## Contents

### Special Article

NEW, IMPROVED GROUP INSURANCE PROGRAM CAN PROVIDE ADDITIONAL PROTECTION FOR YOU	349
--	-----

### Scientific Articles

PRESURGICAL IRRADIATION FOR BRONCHOGENIC CARCINOMA Donald L. Paulson, M.D.	351
ALCOHOLISM—A COMMUNITY PROBLEM, A MEDICAL RESPONSIBILITY A. John Mooney, M.D.	358
RECENT CONCEPTIONS OF DEPRESSION Marion B. Richmond, M.D.	363
VAGINAL DISCHARGE IN CHILDREN, A PRACTICAL APPROACH TO THERAPY John P. Canby, Major, MC	367

### Editorials

THE ROLE OF THE SYMPATHETIC NERVOUS SYSTEM IN SODIUM EXCRETION	371
GEORGIA PHYSICIANS TO RECEIVE INCREASED BENEFITS IN NEWLY REVISED LIFE INSURANCE PROGRAM	372
RADIOLOGISTS AND HOSPITAL CHARGES	373
AMA HOUSE OF DELEGATES CALLS SPECIAL MEETING AT CHICAGO	373
DIABETES DETECTION	374

### Features

President's Letter	378
Cancer Page	379
Heart Page	381
Legal Page	383
Mental Health Page	387

### The Association

Deaths	388
County Medical Societies	388
Speciality Societies	388
Personals	389

### Cover

Design by Jack Niles, Atlanta

### EDITOR

Edgar Woody, Jr., M.D.

### MANAGING EDITOR

Miss Merrillie M. Davis

### STAFF

Thelma V. Franklin, *Business*

### CONTRIBUTING EDITORS

Herbert S. Alden, M.D.; Pres-  
ton D. Ellington, M.D.; Thomas  
Findley, M.D.; J. Willis Hurst,  
M.D.; Charles S. Jones, M.D.;  
Arthur M. Knight, Jr., M.D.;  
Arthur J. Merrill, M.D.; Lester  
Rumble, Jr., M.D.; Peter L.  
Scardino, M.D.; Patrick C.  
Shea, Jr., M.D.; Robert H.  
Vaughan, M.D.

### PUBLICATIONS COMMITTEE

George H. Alexander, M.D.;  
Walter E. Brown, M.D.; J. G.  
McDaniel, M.D.; Henry S. Jen-  
nings, M.D.; Charles R. An-  
drews, Jr., M.D.; John T. Maul-  
din, M.D.; John S. Atwater,  
M.D.; F. G. Eldridge, M.D.

### THE ASSOCIATION

George H. Alexander, M.D.,  
*Pres.*; Walter E. Brown, M.D.,  
*Pres.-Elect*; J. G. McDaniel,  
M.D., *Past Pres.*; Charles R.  
Andrews, Jr., M.D., *Chm. of*  
*Council*; John T. Mauldin, M.D.,  
*Sec.*; John S. Atwater, M.D.,  
*Treas.*; J. Frank Walker, M.D.,  
*Speaker*; Mr. Milton D. Krueger,  
*Exec. Sec.*; Mr. James M. Moffett,  
*Asst. Exec. Sec.*; Mrs. Catherine  
Wooten, *Asst. Exec. Sec.*

THE JOURNAL OF THE  
MEDICAL ASSOCIATION OF  
GEORGIA, established 1911.  
Owned, edited and copyrighted,  
1965, by the Medical Association  
of Georgia, 938 Peachtree  
Street, N.E., Atlanta, Georgia  
30309. Published monthly under  
the direction of the Council of  
the Association. Subscription  
rate: \$7 per year; \$1 per single  
copy. Second-class postage paid  
at Fulton, Missouri.



## *The Pain Is Gone*

Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

### **'Empirin'® Compound with Codeine Phosphate gr. 1/2 No. 3**

Each tablet contains: Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

Keeps the Promise of Pain Relief



BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.



Special Article

# NEW, IMPROVED GROUP INSURANCE PROGRAM CAN PROVIDE ADDITIONAL PROTECTION FOR YOU

- The group insurance program sponsored, endorsed, and recommended by your Medical Association of Georgia has been revised to offer you more protection. You may be eligible for the new coverage; if you are, you'll want to know more about it. Here are some typical questions, and answers to them, that may help you decide about enrolling in the new program.

**Q.** *How will I be protected by this new package?*

**A.** In three ways. First, by life insurance in the amount of \$10,000, with an automatic double indemnity benefit for accidental death. Along with the life coverage goes dismemberment benefits; the principal amount (\$10,000) for loss of both hands, or both feet, or the sight of both eyes; half the principal amount for the loss of one hand, one foot or one eye.

Secondly, by a choice of disability income benefits which are much greater than the amounts previously available. In addition, new choices of coverage and longer periods of coverage are now available to you.

Thirdly, by major hospital and nursing benefits, which can now provide up to \$15,000 for any one illness or injury.

**Q.** *If I choose to participate in the new program, must I buy the entire package?*

**A.** No. You may pick one, two, or all three portions of the revised package.

**Q.** *What if I am already covered under the old plan, and wish to participate in only one part of the new program?*

**A.** The same principle applies. You may choose one or more parts of the new program to replace the corresponding portion(s) of the old plan.

**Q.** *Can my wife or children be covered under any part of the new program?*

**A.** Yes, your family is eligible for coverage under the major hospital and nursing benefit section of the package. Your wife may participate; so may any unmarried dependent children, if they are less than 22 years of age (28 if attending college).

**Q.** *What will happen to my family's coverage if I die while covered under the program?*

**A.** It will continue automatically—unless your widow specifies otherwise.

**Q.** *If I am already covered under the old plan, and wish to participate in all of the new program, what happens to my old coverage?*

**A.** It is automatically terminated as soon as your new benefits are made effective.

**Q.** *What about rates—how do I know they won't be raised?*

**A.** The premium rate at which you enroll is specifically guaranteed until November 15, 1967.

**Q.** *Will my family receive the full life insurance benefit when I die, even though I have other group insurance coverage?*

**A.** Yes, your beneficiary or beneficiaries will receive the full life insurance amount no matter what other coverage you have.

**Q.** *How can I tell if I am eligible to participate in the new program?*

## INSURANCE PROGRAM / Cont.

**A.** You are eligible if you fall into any of these categories of the Medical Association of Georgia: 1) an active dues-paying member; 2) an active dues-exempt member in postgraduate training (DE2); 3) an active dues-exempt member over 70 years of age (DE5) IF you were covered under the old plan.

**Q.** *Will my physical condition affect my acceptance for the new program?*

**A.** Your answers to the health questions on the application will be disregarded for life insurance if 400 new doctors make application. They will also be disregarded for Major Hospital and Nursing Benefits if a total of 800 doctors request these benefits in the revised form. Disability Income coverage will be issued subject to this information concerning your health.

**Q.** *I am interested in the disability income portion of the program, and I understand that I will be paid the full weekly benefit if I am totally disabled. But what happens if I am ill or injured, and am still able to work part-time?*

**A.** For partial disability such as you have described, that part of the program would pay one-half of the weekly disability benefit, up to a maximum of 26 weeks.

**Q.** *About premiums—will I have to pay them if I become totally disabled by accident or illness?*

**A.** Basically, no. If you are totally and permanently disabled before you reach the age of 60 and for more than 90 days, all further premiums on the *life insurance* portion of the plan will be waived. If you are totally and permanently disabled at any age for a period of more than 90 days, all further premium payments on the *disability income* portion of the plan will be waived.

**Q.** *Another question on disability income: Will I receive benefits if I am disabled because of a mental or nervous disorder?*

**A.** Yes, if you are totally disabled and are continuously confined in an institution.

**Q.** *What about my coverage under the hospital and nursing portion of the plan, if disability results from mental illness?*

**A.** You would receive 50% of nursing and hospital costs, after a deductible of \$500, up to a maximum of \$15,000 for any one period of disability.

**Q.** *What happens to my coverage if I retire from active practice or leave the Association?*

**A.** You may convert the *life insurance* portion of the program to a permanent plan of individual insurance in the same amount.

**Q.** *How will I pay the premiums on the new program?*

**A.** Either once or twice a year. Premiums are normally due on May 15 and/or November 15 of each year, depending upon the payment method you use.

**Q.** *Who underwrites this group insurance plan for the Association?*

**A.** Your coverage is provided by Life Insurance Company of Georgia, the state's largest life insurance company. An old line legal reserve company based in Atlanta, Life of Georgia has served the South since 1891. It has more than 125 local offices in major cities throughout 11 Southern states, including 25 in Georgia. Life of Georgia has more than two and a quarter billion dollars of life insurance in force, and assets of more than a quarter of a billion dollars.

**Q.** *How can I get detailed information on the new program?*

**A.** You will soon receive in the mail a complete description of the package, along with a table of rates and an application form. If you have any questions about the program—now, or after you receive the material—you may contact your local Life of Georgia agent, or write to the Group Department, Life Insurance Company of Georgia, 615 Peachtree Street, N.E., Suite 401, Atlanta, Georgia 30308.

**Q.** *How do I apply?*

**A.** Simply fill in the application form you will receive and mail it according to the instructions; or if you wish, contact the Life of Georgia agent in your area.

**Q.** *Should I send my check for premiums along with the application?*

**A.** No. When your application has been approved you will be notified and billed for the proper premium.

---

THE 1966 MEMBERSHIP ROSTER OF THE MEDICAL ASSOCIATION OF GEORGIA  
WILL BE INCLUDED AS A SUPPLEMENT TO THE JANUARY 1966  
ISSUE OF THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA



# PRESURGICAL IRRADIATION FOR BRONCHOGENIC CARCINOMA

Donald L. Paulson, M.D., *Dallas, Texas*

- Following this procedure, it is possible to carry the line of resection close to the lesion without fear of dissemination or subsequent local recurrence.

THE NATURAL HISTORY of bronchogenic carcinoma is such that localized carcinomas are found in 15% of the cases at the time of diagnosis; another 29% have evidence of regional spread; and the remainder or 56% have remote metastases.<sup>1</sup> Approximately 35% to 40% of the cases of lung cancer are predetermined to be inoperable by cell type, location or early vascular invasion with dissemination and domination of the course of the disease by the metastases.<sup>2</sup> Furthermore, even in the more favorable cell types, regional lymphatic involvement of the hilar, mediastinal or pleural areas occurs in over 75% of the cases.

## Only Curative Treatment

Surgery, in spite of the limitations imposed upon it by the disease, has been the only curative treatment generally accepted for bronchogenic carcinoma in a localized phase. In general, efforts to increase the usefulness of surgery through extended operations on an unselected basis have resulted in higher morbidity and mortality rates without benefit to absolute survival time. At the present time, improvement in results of treatment can best be obtained through a better selection of patients for specific forms of therapy including surgery, irradiation and chemotherapy, improved therapeutic techniques including surgical procedures, and through the use of adjunctive measures such as irradiation in combination with surgery.

Presurgical irradiation may be defined as a means

of preparation of the patient with carcinoma for surgery by modification of the extent and natural course of the disease through the employment of moderate dosage therapy so that the lesion is more amenable to resection without increase in morbidity or mortality. The aims of presurgical therapy are: 1) to limit the extent of the tumor by destruction of cancer cells at the periphery, 2) to produce sclerosis of the vascular bed and sterilize the lymphatics; and, 3) to damage the viability of the remaining malignant cells to decrease their ability to implant themselves and grow if disseminated or left behind at the time of surgery.<sup>3</sup>

*Rationale.* Carcinoma spreads by direct extension, lymphatic involvement, vascular invasion, or implantation. Bronchogenic carcinomas may extend peripherally to the pleura and chest wall, or centrally to the hilum or mediastinum, and lymphatic involvement occurs in a high percentage of lung cancers at the same levels. Biologic characteristics, as cell type, location and immunologic responses of the host, determine the natural course and rate of progression of the neoplasm. Vascular invasion occurs earlier and in a higher percentage of the undifferentiated lesions than in the more slowly growing well differentiated epidermoid carcinomas. Disappointments in surgical treatment may be attributed to unappreciated or occult distant metastases occurring prior to diagnosis, or dissemination, implantation and incomplete resection of all carcinomas at the time of operation.

An increase in the rate of circulating cancer cells has been found during operative manipulation of cancer of the lung directly related to cell type, the site of the tumor, its size, and the presence of

*From the Section of Thoracic Surgery and the Sammon's Irradiation Therapy Center, Baylor University Medical Center, Dallas, Texas.*

*Presented at the 111th Annual Session of the Medical Association of Georgia, May 2, 1965, Augusta, Georgia.*



## Bronchogenic Carcinoma / Paulson

metastases or invasion of neighboring structures.<sup>4</sup>

Although tumor embolism is not tantamount to metastases, Cole<sup>5</sup> and his coworkers have shown that the presence of a shower of cancer cells during an operative procedure is associated with a survival rate only one-half that of patients with negative blood samples during operation. Operation or operative stress increases the number of tumor takes in animals compared with their controls.<sup>6</sup>

It is obvious that complete surgical resection or sterilization of local carcinoma by irradiation cannot change the prognosis in the presence of vascular invasion or occult distant metastases at the time of diagnosis.<sup>7</sup> On the other hand, clinical and experimental observations indicate that presurgical irradiation in doses that are not sufficient to sterilize or cause regression of the tumors treated decreases local recurrence, prevents the growth of tumor cells after dissemination and increases survival when compared with irradiation or surgery alone.

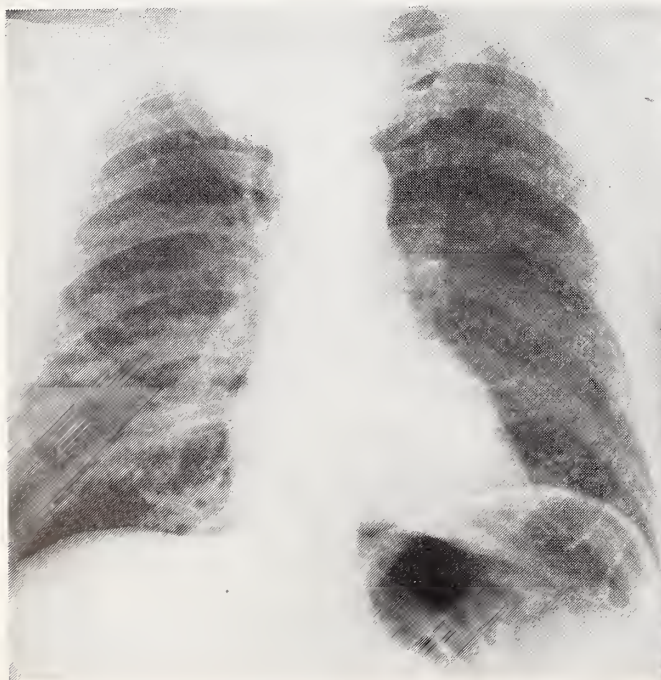
### Roentgen Therapy

Stearns, Berg, and Deddish<sup>8</sup> found that roentgen therapy given preoperatively to patients with cancer of the rectum in small tumor doses (1,200 to 1,600 r) improved the survival rate of patients with poorest prognosis, that is those with lymph node metastases, and suggest that irradiation administered preoperatively inhibits both the dissemination of cancer cells at the time of operation and their proclivity to im-

plant themselves and grow. Preoperative irradiation with 2,000 r in one week decreased the local neck recurrence rate after radical neck dissection from 33% in the control group to 13% in the irradiated group.<sup>9</sup> Experimentally, Hoyer and Smith<sup>10</sup> working with mice and five different types of tumors, have shown that by administering irradiation 24 hours before operation, in doses not sufficient to stop growth or cause regression of the primary tumor, it has been possible to decrease by 90% the growth of tumor cells after dissemination. Inch and McCredie<sup>11, 12</sup> using a two model system in rats and mice, demonstrated that sub-lethal doses of preoperative irradiation decreased the incidence of local recurrence of both tumors, whereas postoperative irradiation was less effective. Powers and Tollmach<sup>13</sup> found that small doses of presurgical irradiation, in doses not sufficient to sterilize Gardner lymphosarcoma, in mice increased survival when compared with irradiation or surgery alone.

Presurgical irradiation in moderate dosage has converted tumors in the superior sulcus to operable lesions with prolonged survival in some cases.<sup>3, 14, 15</sup> Previous experience was poor whether the patient received no treatment, irradiation alone or resection followed by irradiation.

Bronchogenic carcinomas developing peripherally in the upper lobe of either lung and invading the superior pulmonary sulcus (Pancoast tumor) are usually low grade epidermoid carcinomas which grow slowly and metastasize late. Situated in the narrow confines of the apex of the chest, they invade the



\*FIGURE 1A

Bronchogenic carcinoma (squamous cell) in the superior sulcus resected en bloc with involved portions of ribs, bodies of vertebrae, nerve trunks, and apical segment of upper lobe on August 24, 1956, one month after irradiation therapy.

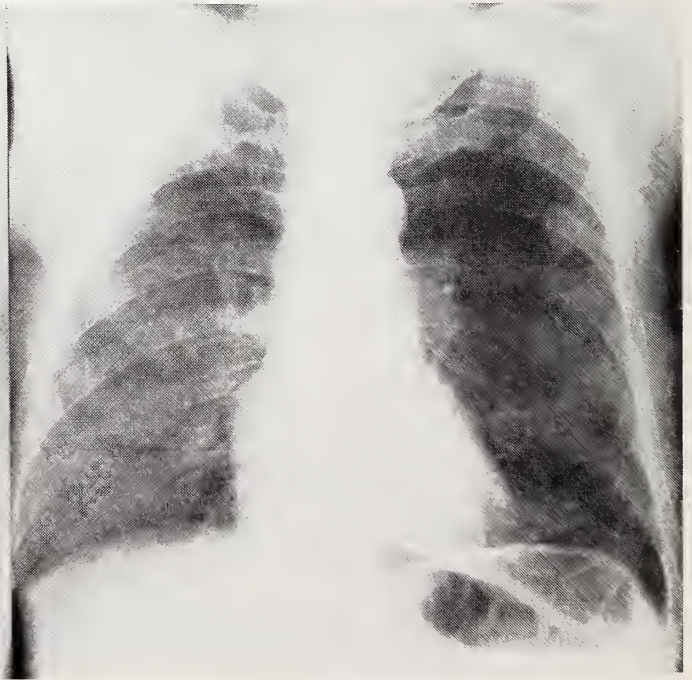


FIGURE 1B

Appearance of chest one year after resection. The patient is alive and well now eight years following combined treatment.

\* From Paulson et al.: *The Journal of Thoracic and Cardiovascular Surgery* 44:281, 1962, published by the C. V. Mosby Co.



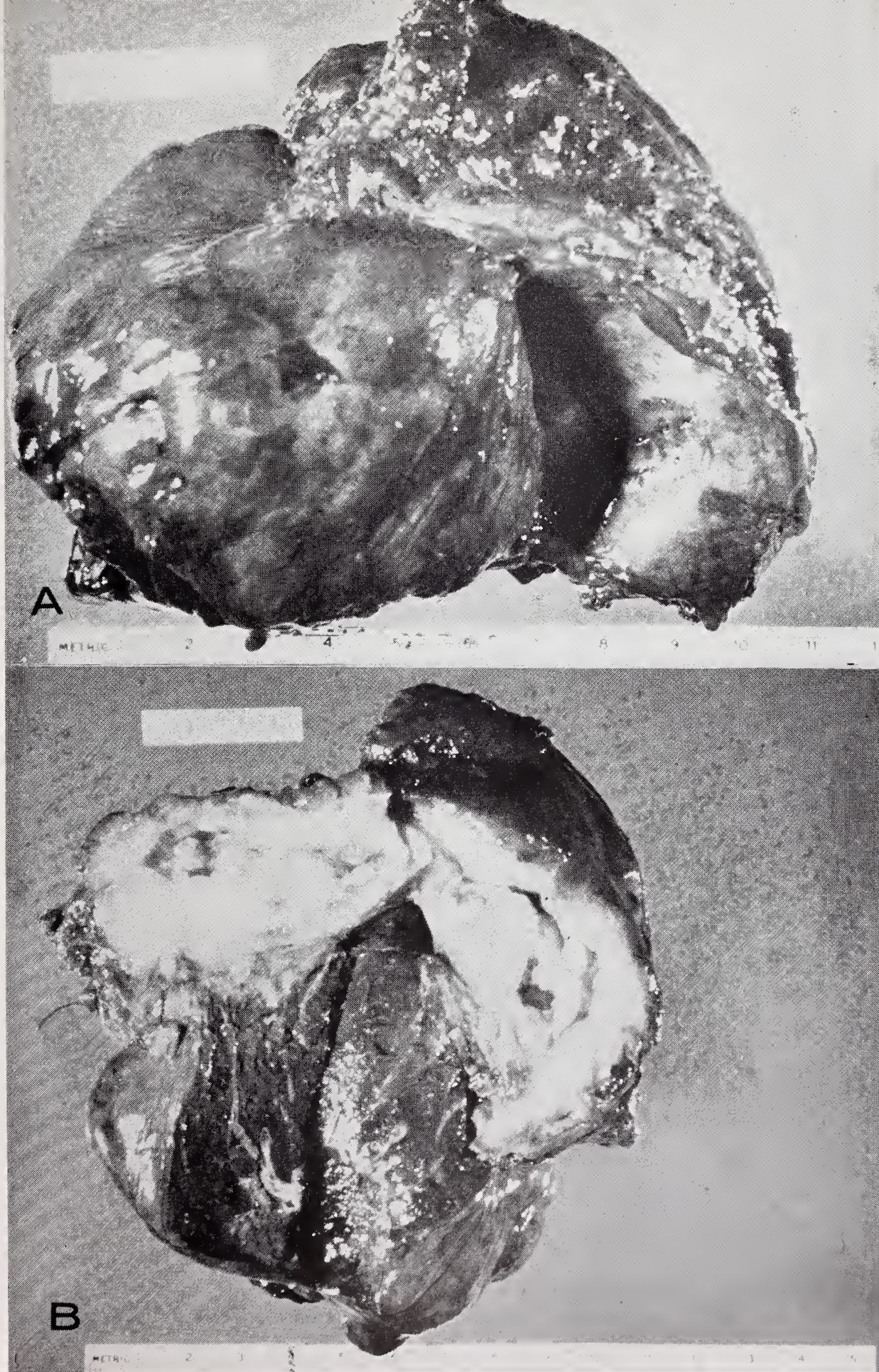


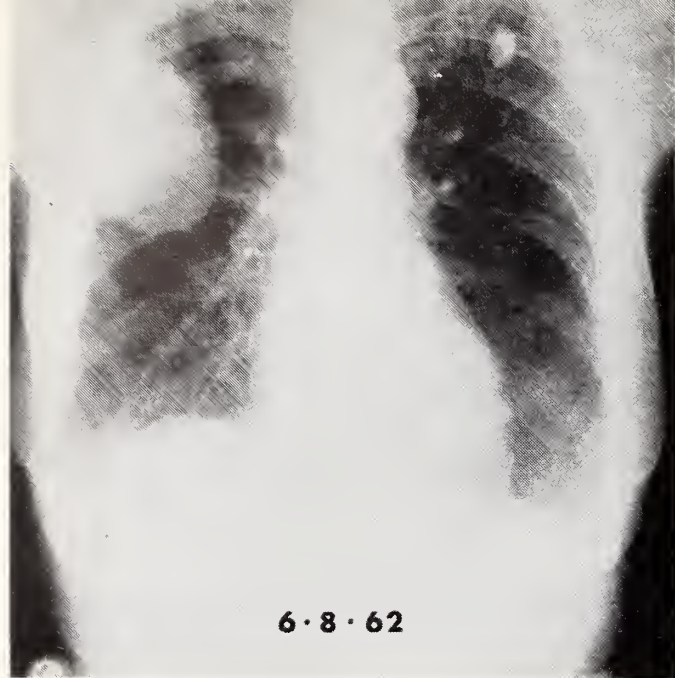
FIGURE 2A

Gross specimen revealing portion of lung and chest wall composed of ribs, intercostal structures, and nerve trunks.

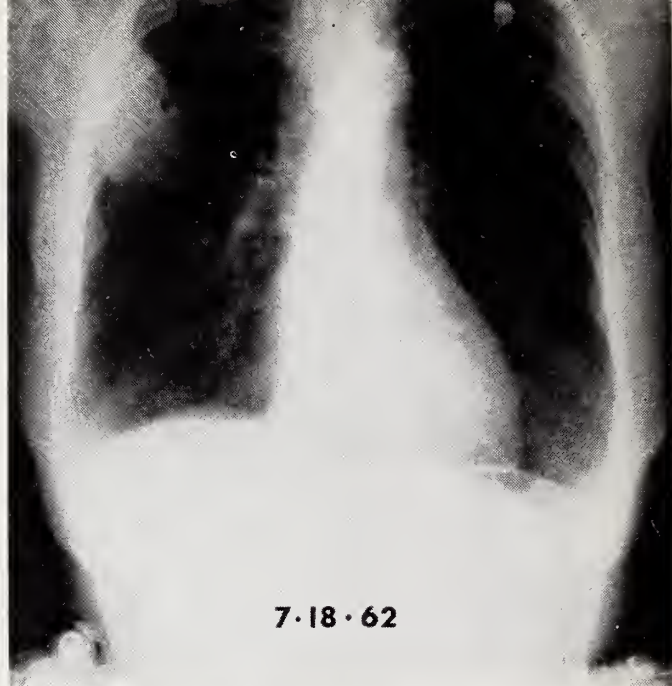
FIGURE 2B

Cut section through specimen reveals the larger portion of the mass to be in the chest wall with a peripheral sclerotic pseudo-capsule and central degeneration.

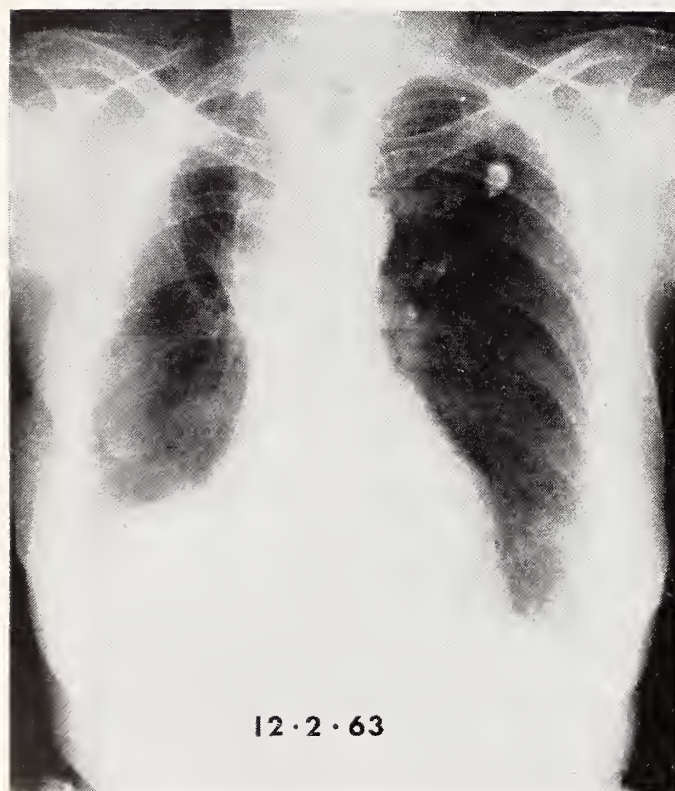




A



B



C

**\*FIGURE 3**

Squamous cell carcinoma right upper lobe with involvement of chest wall. A. (upper left) June 8, 1962, original appearance. B. (upper right) July 8, 1962, three weeks after completion of irradiation therapy. C. (lower left) December 2, 1963, appearance of the chest 16 months after right upper lobectomy with en bloc resection of chest wall (segments of 3rd, 4th, and 5th ribs).

gical irradiation (3,000 r in 10 treatments). Twenty-six patients underwent combined presurgical irradiation and radical resection over two years ago. Of these, nine patients are alive and well two to eight years later including five over five years. One patient has survived eight years (Figure 1); one at seven years; three at five years; two at four years; one at three years and one at two years. Although previous experience does not constitute a strict control, the results would appear to be significant in the conversion of an inoperable lesion in this location with a poor prognosis to a resectable one with prolonged survival.

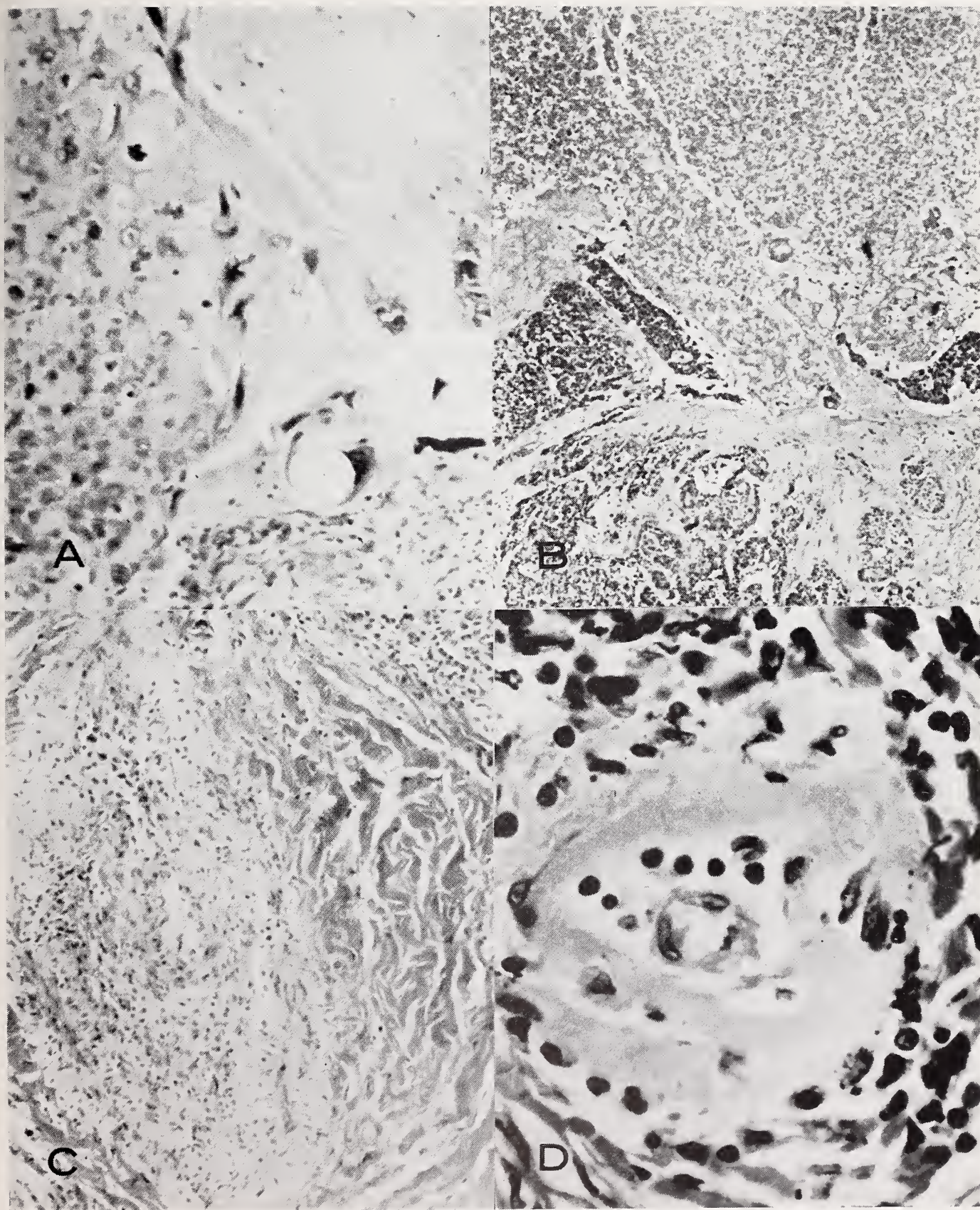
Pathologic examination of the specimens resected four to six weeks after completion of presurgical irradiation has shown a profound alteration in the neoplasm. Grossly, there is a peripheral pseudocapsule and central degeneration (Figure 2). The lymphatics in the extrapleural plane adjacent to the neoplasm have been fibrosed and no neoplastic cells can be found. The periphery of the tumor has been reduced to a desmoplastic mass so that it is necessary to take sections deep within the lesion to find typical neoplastic cells. In the intermediate zone, scattered cells with pyknotic nuclei can be seen as remains of damaged cancer cells. The pathologic findings indicate marked destruction, fibrosis, and localization of the neoplastic mass by irradiation so that it is possible to carry the line of resection close

lymphatics in the endothoracic fascia and involve by direct extension the lower roots and trunk of the brachial plexus, the intercostal nerves, the stellate ganglion, the sympathetic chain, adjacent ribs and vertebrae producing severe pain and the Horner's syndrome. Generally, such tumors have been considered as not accessible to complete surgical removal and to resist all efforts at irradiation treatment. Average expected time of survival reported in the literature and in our own experience has been 10 to 14 months.

Since 1956, 43 patients with tumors in the superior sulcus have been treated by means of presur-

\*From Paulson et al.: *The Journal of Thoracic and Cardiovascular Surgery* 44:281, 1962, published by The C. V. Mosby Company.





\*FIGURE 4

(A) Degenerating and viable squamous cell carcinoma with foreign body reaction and fibrosis at the periphery. (B) Necrosis of squamous cell carcinoma. (C) Squamous cell carcinoma and scarring with encapsulation in a deeper zone. (D) Vascular intimal fibrosis and scarring.



to the lesion without fear of dissemination or subsequent local recurrence.

Carcinomas involving the chest wall by direct extension at levels other than the superior pulmonary sulcus have been treated in six patients with encouraging results as to resectability and survival (Figure 3). It is believed that where the crucial line of extension of the carcinoma is at the chest wall level that presurgical irradiation is particularly of value in sterilizing and blocking the lymphatic involvement as well as limiting the extent of the tumor. The carcinoma itself is often a slow growing relatively localized lesion except for involvement of the chest wall.

Because of the apparent ability of presurgical irradiation to improve the results of radical resection for bronchogenic carcinoma in the superior sulcus, a similar approach has been made to lesions involving the hilar and mediastinal areas since October, 1960. Through 1964, 54 selected patients whose diagnosis was established by biopsy, either by bronchoscopic examination or cervical mediastinal exploration, or both, have been treated by means of presurgical irradiation in moderate dosage in preparation for radical resection one month later. These have included operable as well as 11 initially inoperable lesions. Selection has been based on the combined opinion of the surgeon and radiologist that by means of presurgical irradiation the involvement of the hilar or mediastinal lymphatic drainage areas could be sterilized and the patient either rendered more suitable for resection with improved results or converted from an inoperable to an operable status with benefit to the patient at reasonable risk. In some instances, a lesion which would initially require pneumonectomy has been made suitable for lobectomy by presurgical irradiation.

Radical pneumonectomies were done in 23 and radical lobectomies in 31 patients, including 12 sleeve resections of the right main bronchus with bronchial anastomoses.<sup>16</sup> Four surgical mortalities occurred, two following pneumonectomy and two after lobectomy. One of the deaths was due to hemorrhage from the pulmonary artery 23 days after an uncomplicated lobectomy and bronchoplasty, another was due to bleeding from the atrium nine days after a radical pneumonectomy, a third death was due to pulmonary insufficiency five days after a bilobectomy and the fourth death was due to cardiac failure four days after pneumonectomy. Two of the postoperative deaths were in patients considered inoperable initially. There were three empyemas and one bronchial fistula. All of the 12 bronchial anastomoses, following sleeve resection of the right main bronchus, healed well primarily, but one patient, ini-

tially inoperable, developed a recurrence at the anastomotic site 18 months later. He eventually died of mediastinal carcinoma without distant metastases.

### Irradiation Difficult to Ascertain

The vagaries of the bronchogenic carcinoma, the high incidence of vascular invasion and the complexity of hilar and mediastinal lymphatic drainage make the value of presurgical irradiation in these areas extremely difficult to ascertain. It can be concluded from this study to date, however, that presurgical irradiation when applied in moderate dosage (4,000 r in four weeks) on a selective basis is feasible, apparently without an appreciable increase in surgical morbidity or mortality, that involved mediastinal lymph nodes can be sterilized, and that some initially inoperable lesions can be converted to an operable status. Because of the small number of cases, the short period of follow-up, the selection of cases for treatment and the problem of control, conclusions concerning survival are not justified at this time.

Pathologic observations, as in the case of bronchogenic carcinoma in the superior sulcus, reveal profound damage to the carcinoma with necrosis, degeneration, and sclerosis of the lesion and involved nodes as a result of irradiation. Multiple zones of alteration are found consisting of interstitial pulmonary fibrosis adjacent to the tumor, a mass of scar tissue at the periphery of the tumor appearing as a pseudo capsule, but containing islands of necrotic tumor, foreign body giant cell reaction with degenerating and viable tumor in the deeper areas associated with varying amounts of desmoplastic reaction (Figure 4). In other areas, vascular intimal fibrosis with narrowing of the lumen and occasional thromboses are seen.

### Discussion

Selection of patients for combined presurgical irradiation and radical resection for bronchogenic carcinoma is based on limitation of the disease to the thorax. Age, pulmonary and cardiac function as well as cell type, location, rate of progression and extent of neoplasm are all important considerations. Right sided lesions, particularly those arising in the upper lobe are more favorable for resection than those on the left. Careful cervical mediastinal exploration and search for possible metastases to the liver, adrenals, bone and brain using newer biochemical and scanning techniques are desirable. Pleural effusion, involvement of the trachea, coryna, vena cava, evidence of pericardial or myocardial involvement or extensive mediastinal lesions are indications of a poor prognosis and usually contraindicate surgical interference with or without presurgical irradiation.

Involvement of the chest wall by direct invasion



from a peripherally located carcinoma, whether it be located in the superior pulmonary sulcus or at a lower level, is a clear-cut indication for presurgical irradiation, since it is in this group of cases that objective evidence of the beneficial effects of this approach in survival is available.

Although histologic proof of the clinical diagnosis is desirable prior to the institution of presurgical therapy, insistence on tissue to the extent of injudicious needling or thoracotomy is to be avoided. Examination of sputum and bronchial secretions for malignant cells, bronchoscopic biopsies and careful cervical mediastinal exploration are justified. On the other hand, major surgical interference as by thoracotomy increases the risks of dissemination and decreases the radiosensitivity of the tumor. It is believed that any interference or violation of the vascular bed of the carcinoma and its lymphatics or the introduction of hematoma, low grade infection or inflammation, decreases the responsiveness of the lesion to irradiation therapy and may jeopardize the opportunity for ultimate successful eradication of the neoplasm. In some instances, as in the case of an inaccessible bronchogenic carcinoma in the superior sulcus, treatment is instituted on the basis of a clinical diagnosis only and proof obtained after resection of the remaining lesion.

## Conclusion

It would seem reasonable that through localization of certain types of bronchogenic carcinoma by destruction of tumor cells at the periphery; inhibition of dissemination and implantation by damage to the viability of the remaining cancer cells; sclerosis of the vascular bed; and sterilization of the lymphatics, that survival after combined presurgical irradiation and radical resection would be increased. Objective proof is available in the small group of superior sulcus tumors. How large an increment, if any, may be obtained in the hilar and mediastinal areas depends on the selection of patients for treatment and further study. It is in the lesions with lymphatic involvement either at the chest wall or the mediastinal areas that the dangers of dissemination or incomplete removal at operation are greatest and the prognosis with surgery alone is poor. In the presence of a low grade lesion such as an epidermoid carcinoma with chest wall involvement or evidence of hilar or mediastinal nodal involvement but without evidence of distant metastases, presurgical irradiation may find its greatest usefulness in improving resectability and prolonging survival.

## REFERENCES

1. Cancer of the Lung, California Tumor Registry: Cancer Registration and Survival in California; Calif. St. Dept. Health, 171, 1963.
2. Paulson, D. L., and Shaw, R. R.: Early Detection of Bronchogenic Carcinoma; *J.A.M.A.* 146:525, 1951.

3. Paulson, D. L.; Shaw, R. R.; Kee, J. L.; Mallams, J. T., and Collier, R. E.: Combined Preoperative Irradiation and Resection for Bronchogenic Carcinoma; *J. Thorac. Cardio. Surg.* 44:281, 1962.
4. Scheinin, T. M., and Koivuniemi, A. P.: Factors Influencing the Occurrence of Circulating Malignant Cells in Lung Cancer; *Cancer* 16:639, 1963.
5. Roberts, S.; Jonasson, O.; Long, L.; McGrath, R.; McGrew, E. A., and Cole, W. H.: Clinical Significance of Cancer Cells in the Circulating Blood: Two to Five Year Survival; *Ann. Surg.*, 154:362, 1961.
6. Buinauskas, R.; McDonald, G. O., and Cole, W. H.: Role of Operative Stress on the Resistance of the Experimental Animal to Inoculated Cancer Cells; *Ann. Surg.* 148:642, 1958.
7. Collier, F. C.; Blakemore, W. S.; Kyle, R. H.; Enterline, H. T.; Kirby, C. K., and Johnson, J.: Carcinoma of the Lung: Factors Which Influence Five Year Survival With Special Reference to Blood Vessel Invasion; *Ann. Surg.* 146:417, 1957.
8. Stearns, M. D., Jr.; Berg, J. W., and Deddish, M. D.: Preoperative Irradiation of Cancer of the Rectum; *Dis. Colon and Rectum* 4:403, 1961.
9. Henschke, U. K.; Frazell, E. L.; Basaris, B. S.; Nickson, J. J.; Tollefsen, H. R., and Strong, E. W.: Local Recurrences After Radical Neck Dissection With or Without Preoperative X-ray Therapy; *Radiology* 82:331, 1964.
10. Hoyer, R. C., and Smith, R. R.: Effectiveness of Small Amounts of Preoperative Irradiation in Preventing Growth of Tumor Cells Disseminated at Surgery: Experimental Study; *Cancer* 14:284, 1963.
11. Inch, W. R., and McCredie, J. A.: Effect of Small Dose of X-Radiation on Local Recurrence of Tumors in Rats and Mice; *Cancer* 16:595, 1963.
12. Inch, W. R., and McCredie, J. A.: Preoperative Use of a Single Dose of X-Rays: Local Cancer Recurrence; *Arch. Surg.* 89:398, 1964.
13. Powers, W. E., and Tolmach, L. J.: Preoperative Radiation Therapy: Biological Basis and Experimental Investigation; *Nature* 83:509, 1964.
14. Shaw, R. R.; Paulson, D. L., and Kee, J. L., Jr.: Treatment of the Superior Sulcus Tumor by Irradiation Followed by Resection; *Ann. Surg.* 154:29, 1961.
15. Mallams, J. T.; Paulson, D. L.; Collier, R. E., and Shaw, R. R.: Presurgical Irradiation in Bronchogenic Carcinoma, Superior Sulcus Type; *Radiology* 82:1050, 1964.
16. Paulson, D. L., and Shaw, R. R.: Results of Bronchoplastic Procedures for Bronchogenic Carcinoma; *Ann. Surg.* 151:729, 1960.

## CDC'S DR. ALEXANDER LANGMUIR WINS ONE OF 1965 BRONFMAN PRIZES

One of three of the American Public Health Association's 1965 Bronfman Prizes has been won by Atlanta's Alexander D. Langmuir, M.D., of the U. S. Public Health Service, Communicable Disease Center.

Established in 1961 with a grant from the Samuel Bronfman Foundation, Inc., the \$5,000 awards are for meritorious achievement in the public health field. The October 18, 1965, issue of *Medical Tribune* has described Dr. Langmuir as, "a brilliant innovator in epidemic control." Dr. Langmuir was cited as, "founder and guiding light of the elite Epidemic Intelligence Service."

When polio vaccine was first introduced, Dr. Langmuir and his staff were responsible for tracking down a number of paralytic cases to defectively manufactured vaccine, thereby preventing a major disaster. Because of this incident, Dr. Langmuir established a national polio surveillance program.

Other winners were Dr. Guillermo Arbona, Director of the Puerto Rico Department of Health; and Dr. George James, New York City Health Commissioner.

# ALCOHOLISM— A COMMUNITY PROBLEM, A MEDICAL RESPONSIBILITY

A. John Mooney, M.D., *Statesboro*

- A study of alcoholics is outlined which can be instituted in any community with minimum organization.

THE MEDICAL PROFESSION has declared officially that alcoholism is a disease. But do we as physicians really believe that it is a sickness like other sicknesses? Is alcoholism an actual disease entity? Or do we mean that the excessive drinking in alcoholism is a behavioral disorder growing out of a deeper underlying emotional or mental condition?

Do our actions belie our words? Do we say alcoholism is a disease and then without a flicker for contradiction approve hospital regulations excluding the alcoholic from general medical wards? Or limit admission privileges by demanding advance cash deposits not required of other patients?

## Complex Nature Makes the Attitude

There is considerable evidence that alcoholism may be regarded as a sort of tongue-in-cheek or fingers-crossed disease; a disease, yes, but not just like other illnesses.

This attitude stems not so much from disinterest or lack of information on the part of the physician as from the complex nature of alcoholism itself.

The truth is that, in spite of the great amount of time, energy, and money being spent on the study of alcoholism, very little basic truth has been uncovered. Even the foremost scholar in the field, Dr. E. M. Jellinek, said two years before his death that in alcoholism only two things are constantly present—alcohol and damage. The total cause or causes of the condition remain obscure.

In general there are two ways to approach alcoholism. If one believes that the basic condition is a serious emotional or mental disorder which causes the person to drink excessively, then the natural approach is to prescribe psychotherapy in order to resolve the pathological condition to such a degree that escape through alcohol is no longer necessary.

## A Disease Entity

On the other hand, if one believes that alcoholism is a distinct disease entity, the natural approach is to regard the ingestion of alcohol as the primary cause of the condition. The other abnormal behavioral characteristics, including the emotional and mental manifestations, can then be treated as symptoms of the condition instead of causes. Since many people who consume large amounts of alcohol do not become alcoholics, it can be assumed under the disease entity concept that certain people are either born with or acquire a presently unidentified deviant functional process, possibly bio-chemical, which combined with alcohol over a period of time produces the varicolored complex known as alcoholism.

Another difference between the two approaches is evident. The psychotherapeutic program must concern itself with the problem of why the alcoholic drinks. To discover the cause of the excessive drinking becomes vitally important. As the cause or causes of alcoholism in general have never been adequately outlined, a search into a specific alcoholic's personality to find out why he drinks too much is likely to be disappointing.

*Presented at the 111th Annual Session of the Medical Association of Georgia, May 3, 1965, Augusta, Georgia.*



According to the specific disease concept, why the person drinks excessively is of minor, if any, value as far as recovery is concerned. The vital factor is for the alcoholic, first of all, to be convinced that he is an alcoholic and can not tolerate alcohol in any form. Rehabilitation then consists in the institution of a program of recovery designed to help the alcoholic learn to live comfortably without alcohol. Alcoholics readily become habituated to drug substitutes such as sedatives, tranquilizers or stimulants. If one is to pursue the idea that alcoholism is a specific entity, perhaps bio-chemical in nature, then there is no place for the routine use of such mood-changing drugs in long-range therapy of the uncomplicated alcoholic.

### **Absence of Diagnostic Criteria**

A major stumbling-block from a practical standpoint is the absence of dependable diagnostic criteria. The medical profession has been left in the paradoxical position of having declared a pathological process to be a disease and, at the same time, having devised no techniques to positively diagnose the condition.

A reliable diagnostic procedure to prove the presence of alcoholism in an individual is possibly the greatest single need in the rehabilitation effort. Until such a procedure comes along, the best the physician can do is try to help the alcoholic diagnose himself. However, self-diagnosis appears to be necessary, anyway, before a recovery program can be effective.

The fellowship of Alcoholics Anonymous offers a unique opportunity to explore the disease concept of alcoholism from the viewpoint of therapeutic value. No one can deny that AA has been more successful in bringing alcoholics to sobriety than any other agency. To discuss why AA works is not the purpose of this paper. Rather, it is the intention to point out certain basic characteristics of the AA Program which may be of sound scientific value in helping a physician to formulate an effective community alcoholic rehabilitation program.

### **All Are Sober**

First, practically all the members present at any given AA meeting are sober. A history or opinion given by a drinking alcoholic is not likely to be reliable due to personal dishonesty which seems to be a universal characteristic of the condition. On the other hand, statements taken from an alcoholic who is sincerely trying to stay sober and who is conscious of the value of personal honesty in his recovery will usually be reliable.

Second, AA members generally regard alcoholism as a disease in the true sense of the word.

Third, by a process of self-assessment most AA

members have made the diagnosis of alcoholism in themselves, probably as accurate as a diagnosis can be, in light of present knowledge concerning the condition. This allows reasonable assurance that one is dealing with true alcoholics.

### **A Questionnaire**

It appeared that a questionnaire directed to sober alcoholics might shed some light on causal relationships. If knowing the cause of excessive drinking in alcoholism is important, then it may be assumed that a recovered alcoholic who has attained a normal way of life without need for alcohol, should have some knowledge of the underlying emotional or mental condition which resulted in abnormal drinking.

Questionnaires were passed out at two regular AA meetings in Statesboro and one in Savannah. Names were omitted. All alcoholics present at the meetings and willing to cooperate were included in the study. To avoid distortion by selection, no questionnaires were distributed except at these meetings.

Fifty-five alcoholics took part. Forty-six men, nine women. The average age was 47½ and ranged from 32 to 72, a forty-year span. Forty-three were Protestant, one Catholic, no Jewish. Seven gave no religious preference.

Forty-six were married. Nine were divorced. None single. Thirty-three had never been divorced. Nineteen accounted for 37 divorces. One man had been divorced 12 times.

The average age when the first drink was taken was 14½ years and ranged from five to 25. Nine said their mothers drank. Thirty-two said their fathers drank. Nineteen said one or the other of their parents was an alcoholic. To the question, Is your spouse an alcoholic? Five said, "yes." Forty-four answered, "no."

### **Low Bottom**

Twenty-six called themselves low bottom drunks. Eighteen said they were high bottom. Eight either placed a question mark or did not answer. One said middle bottom. Two said both high and low. In general, "bottom" is a term AA members use to classify the severity of the alcoholic condition present when they became sober.

Nine had been committed to mental institutions. Only three said it helped them. Seven of the nine drank again after leaving.

Thirty-three had been sober a year or more, ranging from one year to 13½, averaging four years. Eighteen had been sober from two to eight months, averaging four months. One had been sober eight days; one, five; and one, three. One said he had gotten sober recently.

Other questions were:

Are you an alcoholic? Fifty-two answered, "yes." One placed a question mark. Two did not answer.

Have you had slips since coming to AA? Thirty-one (56%) said they had not. Twenty-three said, "yes" and one did not answer.

Have you been treated at a rehabilitation clinic? Twenty answered, "yes." Eleven of these were treated in the Georgia Rehabilitation Service, five as inpatients in The Georgian Clinic, six as outpatients in the Savannah Clinic. Seventeen said clinic treatment helped them. One said it did not and two did not comment. All who had been patients in the Georgia Service said it helped them. Eleven drank after leaving clinics, six did not.

Do you believe alcoholism to be a disease? Fifty-three answered, "yes" and two said it was not.

Not so many seemed to be convinced that alcoholism is irreversible. Asked, do you believe that alcoholism is incurable and that you can never again drink successfully? Thirty-six said, "yes." Four said, "no." Fifteen did not answer.

Finally, the following questions were asked:

(1) Why did you drink excessively?

Thirty-two either did not answer at all or said they did not know. Eight answered, "Because I am an alcoholic" or "Because I wanted to."

The others gave these reasons: "Inferiority complex," "self-pity," "character defects," "compulsion I can't explain," "to escape reality," "frustration, mental instability," "compulsion," "escape-immaturity," "excuses," "many excuses," "effect," "trying to escape problems," "be somebody I wasn't," "whiskey gave me courage when first started, later became compulsion or way of life," "it made me what I thought I wanted to be," "trying to hide."

(2) To what do you attribute your sobriety?

Thirty-five attributed their sobriety to AA. Six attributed sobriety to the Church. Ten said they needed AA and the Church. Others said, "understanding and accepting the fact I can't drink," "quit drinking," "desire to live more useful life," "God and help of friends."

(3) In your opinion speaking only of yourself, what do you think was the cause of your alcoholism?

Twenty-one either left the question blank or said they did not know. Fifteen expressed the cause in terms of excessive drinking, such as, "drank too much too long," "progressive drinking," etc.

One said, "Born to be one." Two said, "Trying to be something I wasn't." Others gave such answers as, "Liked what effects did," "resentment," "lack of self-control," "ego, escape, etc.," "wanting to be long, etc.," "don't know too much," "emotional immaturity."

(4) Do you think it is necessary to know the cause of your excessive drinking in order to stay sober?

Forty said such knowledge was not necessary. Fourteen said that it was. It is interesting that of these fourteen, seven had been patients in alcoholic rehabilitation institutions.

To get some idea as to the quality of the individual's sobriety, the following, admittedly ambiguous, question was asked:

If by some magical process you could become a non-alcoholic and be able to drink socially without excess or other trouble, would you drink again?

Surprisingly, 31 said they would not drink again even under these conditions. Two said probably not. One said possibly. Only nine said they would. The others were noncommittal.

Although certainly inconclusive, as alcoholism investigations usually are, this study of alcoholics does suggest an approach to the problem which can be instituted in any community with minimum organization.

### The Reason Why

Most of the sober alcoholics questioned either did not know why they drank excessively, were vague as to the cause or ignored the question entirely. Therefore, for therapeutic convenience the physician can proceed on the thesis that alcoholism is a definite disease entity and that good results will probably come from an effort aimed primarily at stopping the drinking and teaching the alcoholic how to live comfortably on a daily basis without alcohol. As more than half (56%) of the members questioned said they had been sober since their first AA meeting, an excellent place to start this appears to be AA. The associated trouble, including marital, employment, sociological, psychological, and other difficulties, can be treated as symptoms. The psychiatrist, sociologist, rehabilitation clinic and other agencies specializing in specific areas can be utilized as needed.

### A Community Problem

Although most of the members in the AA Groups questioned had become sober primarily through AA, 20 needed additional help through a rehabilitation facility. This suggests that maximum success can be expected when all agencies coordinate in a united effort to bring help to the suffering alcoholic.

Alcoholism affects nearly every individual in the community adversely in one way or another. It is, without doubt, a community problem.

Assuming that alcoholism is a disease, then it is a medical responsibility to devise and place into operation a comprehensive community program for rehabilitation of alcoholics.



A successful program based on certain principles is in operation in the Claxton, Metter, Louisville and Statesboro areas with gratifying results. Physicians have been active, and cooperation from all agencies, principally AA, welfare, law enforcement, ministerial, employers, Georgian Clinic and psychiatrists has been excellent.

A complicated, formal organization has not been achieved and may not be needed. The principal asset has been the willingness of all parties to cooperate in the effort. It is estimated that more than 200 alcoholics have achieved sobriety through efforts in the listed communities during the past four years.

Following are the principles upon which a community program for alcoholic rehabilitation can be based:

### **Suggested Basic Principles**

*(Community Recovery Program for Alcoholics)*

- (A) ALCOHOLISM IS A SEPARATE AND DISTINCT DISEASE ENTITY.
- (B) ALCOHOLISM IS A TOTAL DISEASE OF THE TOTAL PERSON—BODY, MIND AND SOUL.

Therapy, to be effective must include all three areas. Most alcoholics who have achieved a full measure of recovery and who no longer need alcohol or mood changing drugs in any form say that recovery is threefold.

First, they became convinced that under no circumstances could they take alcohol in the smallest amount without calamitous consequences and that this condition would never change.

Second, that they had to undergo a drastic, psychological change in their outlook on life. They had to change their way of reacting to their feelings and surroundings, to stop running away and to see themselves as they really were. Some needed psychiatric help to achieve this improved state of mind.

Third, and possibly most important, the alcoholic had to reach the point of surrender, to realize that without the help of a power greater than himself he could never adjust comfortably to life without alcohol no matter how determined he was to stay away from the first drink or how well he understood himself. There are few truly sober and happy alcoholics who have not found some contact with a God of their understanding either through the Church, Alcoholics Anonymous or some other source.

- (C) THE GOAL FOR REHABILITATION SHOULD BE COMPLETE RECOVERY.

This means the return to or acquisition of a way of life, characterized by a reasonable degree of serenity, free from abnormal tension or anxiety. The individual should be able to live comfortably as a

useful citizen no different in his adjustments from other individuals in a similar life situation. He should have been relieved of the need for alcohol.

A rehabilitation program should be wary of limited goals. Successes reported in terms of improvement in isolated areas, such as, fewer jail sentences, improved work records, better health or a reduction in the number of drunken sprees in a given period of time may be misleading. All of these things can sometimes be accomplished through sheer determination and will power by the alcoholic who is sufficiently motivated. However, such improvement is usually temporary. Unless it is followed by a psychological change to produce a comfortable sobriety, the alcoholic may break up under the strain and become physically or emotionally ill or both. More often he stands it as long as he can and gets drunk.

- (D) ALCOHOLICS HAVE A PECULIAR SUSCEPTIBILITY TO ANY TYPE OF MOOD CHANGING DRUG.

The alcoholic who has given up alcohol only to become dependent on a tranquilizer, stimulant, sedative or combination of these has not sobered up. He has merely switched drugs. These drugs, often indicated in the acute phase, should not be part of a long range recovery program.

- (E) THE PERSONAL, SOCIOLOGICAL, FINANCIAL AND OTHER PROBLEMS ARE RESULTS OF ALCOHOLISM AND NOT CAUSES.

Help should come from these areas as an aid to achieving sobriety, never with the expectation that solving these problems is going to result in sobriety.

- (F) THE MOST EFFECTIVE AGENCY AVAILABLE TO HELP THE ALCOHOLIC STOP DRINKING IS ALCOHOLICS ANONYMOUS.

This fellowship should be utilized first and to the fullest. Every physician who treats alcoholics should become acquainted with an AA Group, attend meetings and cultivate friendships with AA members.

- (G) SELECTED USE OF PSYCHIATRIC REHABILITATION FACILITIES.

The limited facilities of the professional alcoholic rehabilitation clinics should be utilized for those who cannot become sober by attending Alcoholics Anonymous meetings.

Those who, dry in AA for a reasonable length of time, possibly several months, and who may have been patients in rehabilitation clinics, and yet still have problems of personality with which they are unable to cope, should be referred to psychiatrists.

Individuals going out from AA to other facilities for help should be encouraged to return to AA. Sobriety for the alcoholic is a new, good habit replacing an old, bad one. The need for re-enforcement

is a continuing process. AA is desirable for this because of its effectiveness and also because of its universal availability.

## (H) ALCOHOLISM IS A FAMILY AFFLICTION.

The spouse and the children are usually sick from living with the problem and will also need help and understanding. Associated with AA are the Alanon and Alateen Family Groups which can be helpful.

## (I) THE PHYSICIAN SHOULD ASSUME ACTIVE RESPONSIBILITY FOR THE IMPLEMENTATION AND OPERATION OF A SIMPLE REHABILITATION PROGRAM.

He should cooperate fully with all other agencies concerned with rehabilitation of alcoholics. The most successful effort is a united effort.

The physician should make contact with Alcoholics Anonymous locally. If there is no group, information concerning neighboring groups can be obtained from the AA General Service Office, P.O.

Box 459, Grand Central Station, New York 17, N. Y.

Alcoholism information and literature can also be obtained from The Georgia Alcoholic Rehabilitation Service, 1260 Briarcliff Drive, N.E., Atlanta, Georgia 30306, and The National Council on Alcoholism, Inc., New York Academy of Medicine Bldg., 2 East 103rd Street, New York 29, N. Y.

As the alcoholic may run afoul of the law or seek counsel with a clergyman, the physician should cooperate closely with law enforcement officers, jurists and ministers.

## A Hidden Disease

Alcoholism is often a hidden disease. Practicing alcoholics tend to lie about their drinking. Pride is involved and other members of the family may conceal the full severity of the drinking problem. The case is sometimes presented in such a way that the drinking appears to be a minor problem among many major ones. A good rule to keep in mind is:

If there are problems and if there is drinking, the drinking may be the only problem.

*31 Seibald Street -*

# 1965 CALENDAR OF MEETINGS

## State

For 1965: Postgraduate Courses sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.

September 29-December 15—Psychosomatic Medicine (12 weekly evening sessions)

November 15-19—General Practice Review:

November 15—OB-GYN

November 16—Internal Medicine

November 17—Endocrinology

November 18—Cardiology (a.m.)

The Eye (p.m.)

November 19—Pediatrics

December 1-2—Fractures

December 7-May 12—Georgia Circuit Course (six sessions one day each month at six centers in Georgia)

November 11-13—Postgraduate Course, "What's New in Surgery," sponsored by the Department of Surgery, Emory University School of Medicine, Grady Memorial Hospital Auditorium, Atlanta.

November 15-17—Postgraduate Conference in Gynecologic Cancer sponsored by the Department of OB-GYN of Emory University School of Medicine in association with the Georgia State Obstetrical and Gynecological Society, Grady Memorial Hospital Auditorium, Atlanta.

May 8-10, 1966—112th Annual Session of the Medical Association of Georgia, Columbus.

## Regional

September 15, 1965-June 15, 1966—A nine month tutorial program in Cardiology offered by the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

November 17-20—International Conference on Hyperbaric Medicine (3rd), Duke University Medical Center, Durham, N. C.

December 7-9—Southern Surgical Association, Homestead, Hot Springs, Va.

January 13-15, 1966—American College of Surgeons Sectional Meeting, Bal Harbour, Fla.

January 31-February 2, 1966—American College of Surgeons Sectional Meeting, Houston, Tex.

February 28-March 4, 1966—Seminar in Obstetrics and Gynecology. Cruise to Nassau and Freeport in the Bahamas, *S.S. Ariadne*. Sailing from Ft. Lauderdale, Fla. Presented by the Dept. of Obstetrics and Gynecology, College of Medicine, University of Florida. Approved by Florida State Board of Health, Florida Medical Association, and Florida Academy of General Practice.

## National

November 19-22—1965 Annual Meeting of the National Society for Crippled Children and Adults (The Easter Seal Society), Palmer House, Chicago.

November 28-December 1—American Medical Association (Clinical Convention), Philadelphia.



# RECENT CONCEPTIONS OF DEPRESSION

Marion B. Richmond, M.D., *Kensington, Maryland*

- Depression can and usually does appear in the course of every psychic disturbance.

TO BEGIN WITH, let me with a few concise statements review the story of depression in medical history. In Hippocratic psychiatry (400 B.C.), sluggishness, quietness and dejection were associated with thick black bile. Any hyperactivity or excitement was mania. Aretaeus (250 A.D.), observed that mania developed out of melancholia, or, at times, it was the reverse. Down through the ages these ideas have prevailed. Excessive agitation, movement and happiness was mania. Excessive slowness, quietness and unhappiness was melancholia. One type shifted to another, circularity was recognized.

## Refinements

At the beginning of the present century, and afterwards, we find many refinements of this simple classification. Although they represent remarkably careful and detailed clinical observations, the refinements are nevertheless basically descriptive enterprises. It must always be mentioned that in 1896 Kraepelin gathered together a number of symptom complexes into two main subdivisions: the episodic non-deteriorating manic depressive insanity and the progressive deteriorating dementia praecox. Under the heading of manic depressive insanity, Kraepelin included practically all types of psychotic depression.

In 1926 Mapother asserted that neurotic depression can only be distinguished from the psychotic type by its diminished severity, by the absence of a need for hospitalization. The point was argued at great length, but now after all have had their say, it does indeed seem incontrovertible that the neurotic syndrome merges insensibly into the psychotic one as severity increases. And in addition, the same thing may be said for the relatedness of normal and neurotic depression.

The psychoanalysts, in their study of individuals rather than groups, have amassed a tremendous

amount of greatly detailed material. Although it is quite useful in following psychological processes, and in therapeutic work, it too is essentially descriptive.

## Depression Is Ubiquitous

One thing gets very clear: depression is ubiquitous in mental illness. It can and usually does appear in the course of every psychic disturbance. Note its inclusion in almost every disease syndrome in the American Psychiatric Association's classification handbook. Observe Fenichel's statements in the *Psychoanalytic Theory of the Neuroses*: "It occurs in every neurosis," . . . it is the "most frequent and most problematic mechanism of symptom formation."

I was talking to a colleague a month or so ago, and I had occasion to say to this good friend that it seemed to me that just about all of the members of the society were depressed and underproductive. "Yes," he said, "and anyone who isn't, is a rat-fink."

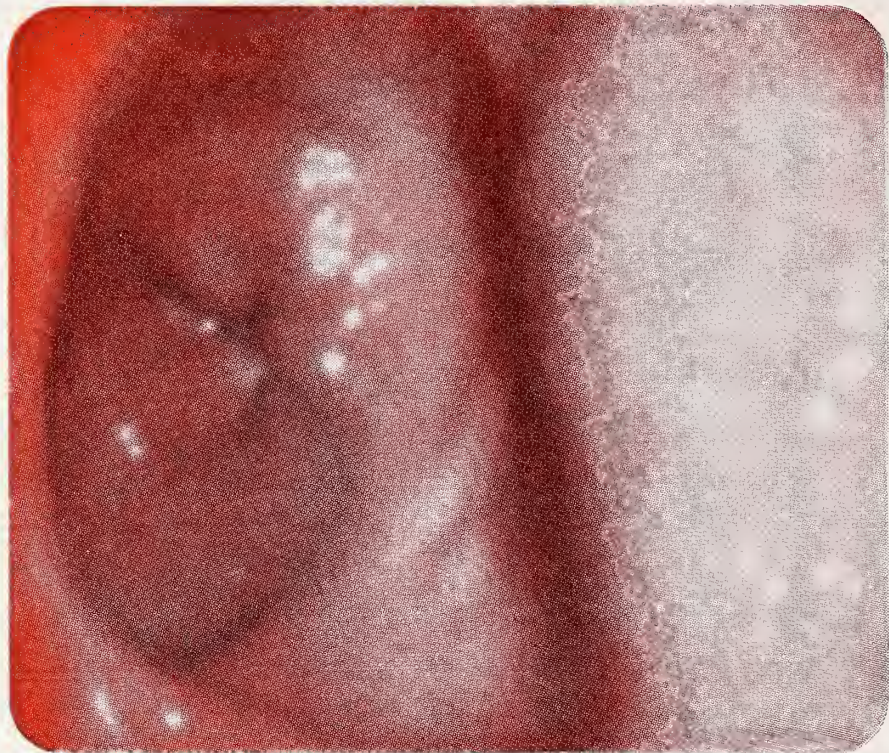
Let us see what the psychoanalysts have to say, using Fenichel's encyclopedic work. The depressive person, he tells us, is fixated in a state where his self-esteem is regulated by external supplies. If he is not fixed at this level, his guilt feelings may drive him to regress there from time to time. He goes through this world in a condition of perpetual greediness. If his needs are not satisfied, his self-esteem diminishes to a danger point. He is ready to do anything to avoid this. He will try every means to induce others to give to him. If he doesn't react to frustration with violence, he may attempt to manipulate with ingratiation and submissiveness.

If you haven't heard yourself described already, you probably will, at least a little bit, as we proceed. I am trying to say that it gets pretty evident that depression shows itself repeatedly, not only in the mental illnesses, but as part of the human condition. The description continues as follows: These persons,

Presented at the 111th Annual Session of the Medical Association of Georgia, May 3, 1965, Augusta, Georgia.

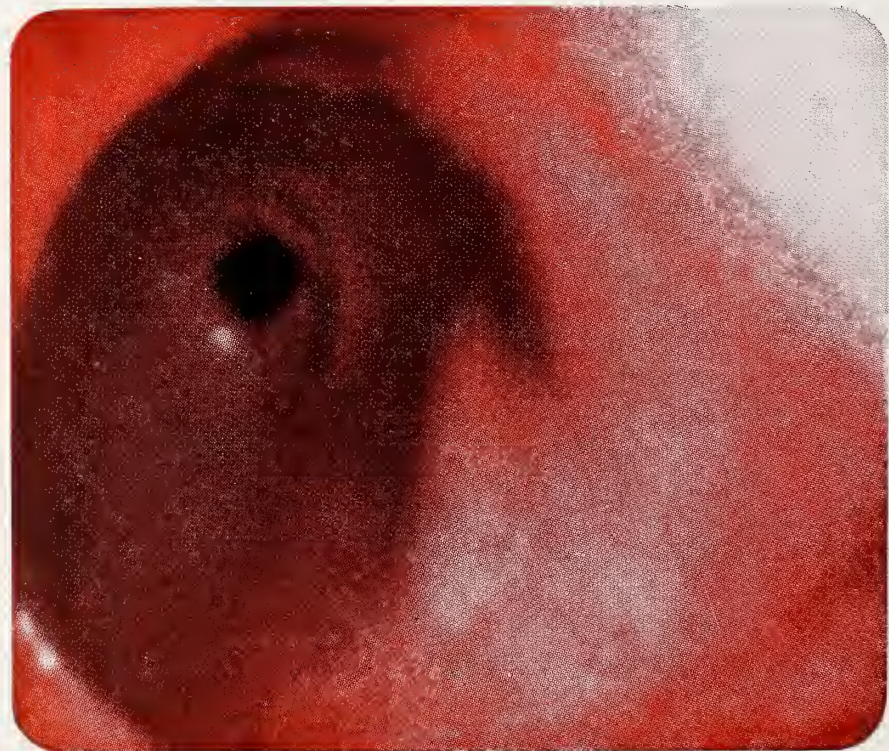


# Intragastric photography studies<sup>1</sup>



**A/** E. B., male, age 48. Normal antral contraction. Pyloric opening is not seen. It is difficult to differentiate a deep prepyloric contraction from a "pyloric fleurette" or true pylorus.

**B/** Same subject after 6 mg. of propantheline bromide intravenously; antral contractions ceased. The pyloric orifice remained open and was easily identified. Better visualization of the antrum was also obtained.





# Now you can see Pro-Banthine® at work (propantheline bromide)

Pro-Banthine is so effective in anticholinergic action that it may be employed in visualizing the entire pyloric region.

In addition to the intragastric photographs, cinegastroscopic studies<sup>2</sup> have demonstrated graphically not only its effectiveness but the superiority of Pro-Banthine over belladonna alkaloids.

Pro-Banthine produced complete cessation of gastric, antral and pyloric motor activity with a dose of 6 mg. intravenously. This is approximately one-third the usual oral dose of 15 mg.

Atropine at full normal dosages did not produce such cessation. It required double the usual oral dose of atropine, 0.8 mg. intravenously, to duplicate the aperistaltic action of Pro-Banthine. This dose of atropine produced pronounced discomfort and tachycardia with ventricular rates as high as 150 per minute.

It is this pharmacologic superior-

ity of Pro-Banthine which has made it the most widely prescribed anticholinergic in such conditions as peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

**Dosage**—The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15 mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily.

**Side Effects and Contraindications**—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

**SEARLE**

*Research in the Service of Medicine*

in their continuous need of supplies to heighten self-esteem, are love-addicts. While they find it difficult to love actively, they passively need to feel loved. They are dependent and choose friends and mates like themselves. They change acquaintances often because no one is able to provide them the necessary satisfaction. Although themselves inconsiderate, they demand understanding of their own feelings. A further characteristic is their need to feel they have done the right thing. Bad conscience can create for them tormented states of diminished self-esteem.

Severe depression represents the state into which such a dependent individual gets when the vital supplies are lacking. In a neurotic depression there is a desperate attempt to force others to come across with the vitally necessary supplies. In the psychotic depression the actual complete loss has already taken place. All negotiations then are intrapsychic, the manipulations are limited to those made at their own consciences.

### The Genesis of Depression

Psychoanalysts are not in agreement as to the genesis of depression. Freud and Abraham postulate a constitutional over-accentuation of oral needs with fixation at the oral level because of overwhelming childhood disappointments. Melanie Klein, however, postulates that all infants go through a developmental phase called the "depressive position." It occurs in the first year and is characterized by phases of savage fantasy with guilt and self-hate. Depressive psychosis in later life can occur when the child has not been loved enough to enable him to develop reality-testing, self-esteem, and optimism. The child with a "good maternal introject" possesses these fortunate attributes.

Enough for now on the psychoanalytic viewpoint. It is easy to see that a depressive, in order to stay well, must learn to effectively position himself with another person, someone with whom he can learn to trade freely. He must do this not only to stay well, but also, perhaps, to stay alive. I remember Lewis Hill saying to his class, facetiously, yet in great truth, "there are only so many good teats in this world, and those that have one are lucky."

### Descriptions Are Easier

In psychiatric literature descriptions are easier to find than clearly determined etiological considerations, and this situation is no different for depression in particular. Attempts to correlate psychopathology with neuropathology have been largely unsuccessful. The connection of syphilitic meningo-encephalitis to general paresis, of atrophy to senility, and of specific lesions to the aphasia led pathologists to hope for

similar disclosures to solve the functional psychic illnesses, but the results have been disappointing. Early in this century concepts of morbid taint and heredo-degenerations preoccupied psychiatrists, and a great deal of time was spent measuring distances back and forth across the human body. The manic depressive came to be associated with pyknic habitus: thick torso, short neck, delicate hands and feet. Today, Kallman, who is the foremost American psychiatric geneticist, states that "some persons have the genetic capacity for reacting to precipitating stimuli with either a schizophrenic or a manic-depressive psychosis. Whether or not . . . psychosis will be developed . . . depends on an intricate interplay of constitutional and environmental factors." Perhaps Kallman's most important contribution is his argument against the association of genetic factors with a fatalistic outlook which would discourage therapeutic activity. Inheritability is not at all inconsistent with energetic treatment. A cleft palate, he suggests, may be rendered normal by surgery, but a gangrenous foot may not respond at all.

It was Adolf Meyer who, in the first quarter of this century, introduced the concept of psychiatric syndromes as reactions to life. Different people react in different ways. Depressive reactions are regarded as faulty reactions to life, or to stress. They are called the thymergasias.

### Human Depression and Stress

The experimental work which I will present to you this morning has been done much in the spirit of Adolf Meyer. It relates human depression and stress—severe mental illness and biochemical evidence of stress. Whether we should call the reactions we witness "faulty reactions to life" remains to be seen. Nevertheless the approach will be, as far as I can tell, essentially a Meyerian one. I have for four years been employed as a psychiatric consultant to the depression project at the National Institute of Mental Health. The chief investigator is Dr. William E. Bunney, Jr., and it is he who has the major credit for the work I am about to describe and about which I shall make a few theoretical observations. So at this point let us relinquish history in favor of a piece of the contemporary scene. It should not surprise you if what I have to say concerns the biochemistry of behavior, neuroendocrine mechanisms and the like, for these are very important in the contemporary psychiatric research picture.

The basic experimental design is a simple one. It is tightly constructed, and it has been statistically validated. It employs behavioral ratings, biochemical assays, and the correlation of these two variables in time.

Behavioral ratings were based on data collected by nurses on a research team which had been in-



tensely trained for six months in systematic methods of observation and recording. What did these nurses observe? Such things as would come under headings of anger, anxiety, depression and psychotic behavior. For instance, items under the heading of depression would be: verbal expressions about worthlessness, suicide, death and hopelessness; a sad facial expression. The items under psychotic behavior included: verbalized crazy thoughts, behaving in a crazy, bizarre manner, and acting or talking as if hearing voices. There were other headings such as somatic complaints and physical activity, but these did not turn out to have the same significance as the key areas, which were depression, anger, anxiety and psychotic behavior. Several members of the nursing team would rate each patient for each item on a 15-point scale. Four hundred scales were examined for rater-agreement. In the four key areas there was amazingly high rater-agreement reliability—less than one chance in a million that the agreements could have occurred by chance.

### Data Collected

Other behavioral data were collected. There were weekly therapy summaries, crisis observations and research discharge summaries by the physicians. Social workers collected information, as did the dieticians, and the patients themselves maintained a daily diary.

Let us move from the gathering of behavioral data to the gathering of biochemical data. Urine was collected throughout hospitalization on every patient. It was pooled in 24-hour samples and later analyzed for an adrenal hormone, 17-hydroxycorticosteroid. This substance is the metabolic end-product of hydrocortisone, a secretion of the adrenal gland. Impulses from the brain cortex stimulate the hypothalamus, which activates the anterior pituitary, which stimulates the adrenal cortex to release hydrocortisone. Hydrocortisone is broken down in the liver and excreted in the urine as 17-hydroxycorticosteroid.

### Between Mania and Depression

It sounds simple: collect the urine in 24-hour samples and analyze it for the key compound. Imagine, however, collecting all of the urine from a patient unable to cooperate, a patient in the utter turmoil which goes with a depressive crisis. It was necessary, during crisis periods, for a nurse to be in constant attendance 24 hours a day. No day could be analyzed in which a loss of urine occurred. Another complication was discovered in the case of a patient who was manifesting a 48-hour cycle of alternation between mania and depression. When her urine was collected in the usual 24-hour periods from 8 a.m. to 8 p.m., there was little difference in chemical levels between

the specimen from the high day and that from the low day. However when it was collected from 12 midnight to 12 midnight, there were marked differences indeed. Charts show highly increased excretion of 17-hydroxycorticosteroid on depressed days, and a marked falling off on days of elation.

The outpouring of hydrocortisone and its metabolic derivatives is an indication that the human organism is under great stress, perhaps more significantly, in great danger. The levels rise in airmen about to take off on a combat mission. They also rise in automobile racing drivers just before a race, but nowhere are they known to increase so precipitously as in the depressive crisis, nor to stay so high as during the depressive episode. Indeed a correlation of predictive value may quite possibly exist between suicide and very high urinary levels of 17-hydroxycorticosteroid.

Dr. Bunney's analysis showed that high positive correlations between depression and urinary 17-hydroxycorticosteroid existed when serial determinations were run over weeks and months for a given patient. However, when mean ratings of the depression levels were taken for each of the patients, a significant correlation was not obtained. Clinical ratings of depression were not always associated with elevated chemical levels. In a given patient, correlation might exist, but between patients it did not. Two subgroups among clinical depressions were differentiated. There was, on the one hand, a group that showed mean chemical levels from two to three times normal, and on the other hand a second group with high mean ratings of depression, yet normal or low 17-hydroxycorticosteroid levels.

### Behavioral Differentiation

In my opinion, the most significant part of this work came in the behavioral differentiation of these two groups. In the group with high chemical levels the patients were, according to Dr. Bunney, "much more involved in a struggle with their illness and their thoughts . . . they seemed to have no effective defenses against them." These patients say things like, "I cannot stop thinking about death," and, "I think all day and night about how I have failed everyone." They appear unable to escape these thoughts, while the group with low 17-hydroxycorticosteroid urinary levels, although afflicted with severe depression as shown by their ratings, showed ability to deny their illnesses. They would say things like, "I'm just here for a physical check-up," or "Doctor, it's my weight loss, that's it, that's what made me sick!"

There is not much with which one can disagree in Dr. Bunney's work. The experimentation is air-tight, and the results are well validated statistically. If I have any difference at all with Dr. Bunney, it is to



the effect that he has not carried far enough his theoretical speculations. It is probably a matter of personalities. He is the scientist, more content to wait for incontrovertible proof of any statement he may make, while I, however, find myself eager to speculate more freely. What about this patient who relates his illness to the soma and says, "Doctor, it's my weight loss, that's it, that's what made me sick!"? Long ago it was clearly understood that depressives often complained of somatic sensations. Every psychiatrist has seen them investigated, *in extenso* but fruitlessly, for various arrays of gastrointestinal complaints. Not a few such patients have gone to surgery. In 1944 Foster Kennedy coined the term "manic-depressive equivalent" to designate a periodic decursus of somatic complaints—with or without attendant mood swings. Many eating disturbances have been described as associated with the depressive trend. Engel (1955) found it "an arresting observation" that patients with ulcerative colitis, at times of symptom onset or relapse indicated in every instance (out of 45 such instances among 39 cases) a feeling tone such as helpless, hopeless, despair or "too much to cope with." There is work now in progress at the George Washington University Hospital in Washington, D. C., under the direction of H. A. Meyersburg, which indicates, again, the strong tendency, this time among "crocks" or hypochondriacs, to explain away life's disappointments, failures and guilts by establishing physical illness as the cause.

### Juvenile's Method of Coping

But it was in 1955 to 1958 that Kaufman and his associates elaborated the concept that delinquency is the juvenile's method of coping with a "depressive nucleus." Here another psychiatric condition, characterized by "acting out," defends against, or, if you will, denies the depressive condition. We have observed in several instances a marked relief experienced by a depressive patient who can form a romantic attachment to another patient or to one of the staff, even though there is only relapse when some

separative event interrupts the relationship. Other patients who are unable to deny their depressions forthrightly with a manic episode toy constantly with threats of going insane. One patient with very high behavioral ratings and extremely high 17-hydroxycorticosteroid levels tried several forms of psychosis, all with pitifully poor success. He mimicked a paranoid, he pretended to be a homosexual and he tried to copy an excited schizophrenic. All of these attempts were transparently unreal. He found no way to escape his intolerably severe tension. Later he committed suicide.

### Many Theoretical Conceptions

Many theoretical conceptions have arisen in the wake of Dr. Bunney's experiments. One of the most interesting poses an imaginary state of undefended psychic pain. Such a state would be intolerable and probably unreachable because of stupor, exhaustion or suicide. The 17-hydroxycorticosteroid levels would be very high. In the undefended state no elations, delusions, hysterics, obsessions or acting-outs would stand between the patient and his ultimate misery. Perhaps he would be an unimaginative character incapable of romance, patriotism, religion, passion, intense exertion, or attachment to any cause. Could it be that he might even be incapable of depression? He would then be incapable of a state which arises in stress yet at the same time manipulates others to relieve the stress, mainly because others can identify with his condition. Many depressives can find good "happy-makers," their symptoms lead others to help; one feels a need to do so. The manic, however, pushes us away, he engenders no wish to help, he may even get us to lean on him. It seems that those people who are able to construct for themselves some form of behavior, relationship or fantasy life which belies, denies or avoids the essential misery of human separation and aloneness are the ones who escape ultimate psychic pain. It could be said that the more honest don't fare so well, yet it seems there should be some way for a person to belie, deny or avoid pain without being regarded as dishonest, neurotic or some kind of a nut.

3211 Wake Drive

## NEW MAG "NEGOTIATING COMMITTEE" HOLDS ORGANIZATIONAL MEETING

Some 18 Georgia Specialty Societies were represented by their appointed members at an organizational meeting of the new Association "Negotiating Committee" created by the MAG 1965 House of Delegates. This Committee was charged with the responsibility of "negotiating with third parties a fee schedule for their specialty (including General Practice) with such fee schedules subject to the approval of MAG Council."

The Committee elected Henry Jennings, M.D., of Gainesville as Chairman and John McCain, M.D., of Atlanta as Vice Chairman. For the representatives' deliberations with their specialty societies, the Committee voted to use the California—1964 Relative Value Schedule as a guideline. This California 1964 Relative Value Schedule was referred to the Committee in revised form by the House of Delegates for their consideration.



# VAGINAL DISCHARGE IN CHILDREN

## A PRACTICAL APPROACH TO THERAPY

John P. Canby, Major, MC, *Fort Benning*

- The most common etiology is a non-specific vaginitis.

VAGINAL DISCHARGE in the child is a common complaint of mothers who bring children for well check-ups. It most frequently is manifested by a greenish or yellowish staining of the undergarments. Although the child is not bothered by this symptom, it frequently is a cause of great anxiety for the parents. Often home remedies have been tried without success. Because of a desire to avoid "emotional trauma" to the patient in the performance of a thorough pelvic examination, or a lack of understanding of the basic problems involved, many physicians experience difficulty in adequately treating these patients. The following discussion is intended to outline the more important causes of vaginal discharge and simple means of treatment.

### Causes of Vaginal Discharge and Irritation<sup>1, 2</sup>

#### A. Non-Vaginal Conditions

1. *Urethritis*: Many conditions such as acid urine, foreign bodies, gonorrhea, or physical irritation may cause swelling and redness of the urethral orifice, dysuria and discharge of pus.

2. *Adhesions of the greater or lesser labia*: This may cause mucous secretion retention which leads to vaginal irritation and causes dysuria because of the small opening remaining for the discharge of urine.

3. *Ectopic ureter opening in the vagina*: This causes a watery discharge from the vagina. These conditions may be easily diagnosed by careful history and inspection of the urethral and vaginal orifices.

#### B. Vaginal Conditions

1. *Physiological discharge*: This is particularly prevalent in the newborn period, frequently with pro-

fuse mucoid discharge. Smegma accumulation is frequent. In the pubescent period a mucous discharge and quantities of smegma are again quite common. During the intervening period a small amount of mucus is constantly secreted and may accumulate, culminating in a "discharge." Physiological bleeding ("menstruation") due to withdrawal of maternal estrogen effect on the infantile uterus may also occur in the newborn period. This bleeding is self-limited and stops in four or five days.

2. *Nonspecific vaginitis*: This is the most common cause of discharge during the childhood years. It seems to reflect poor personal hygiene, although masturbation, eczema, pinworms, foreign bodies, and tight panties frequently play important predisposing roles. Many children seem to be irritated by prolonged exposure to soaps and detergents—particularly those used to make the "bubble baths" which many toddlers enjoy playing for long periods of time. A bath of one-half hour's duration is not unusual. Vaginal cultures reveal a variety of organisms—*pseudomonas*, *E. coli*, *streptococcus*, etc. which are basically contaminants.

3. *Gonorrhea*: This usually causes a thick, purulent discharge, although chronic infection may cause a watery discharge. It may be acquired during passage through the birth canal, or by diapers, toys, contaminated hands, and intimate contact with playmates with gonorrhea. The vagina and vulva usually are erythematous. Thigh, urethra, and rectal excoriation may occur. Local adenitis, urethritis, and proctitis are the most common complications although cystitis, pyelonephritis, endometritis, arthritis, peritonitis, and ophthalmia are possible. Complications are more frequent with increasing age of the patient.

## Vaginal Discharge in Children / Canby

4. *Monilial vaginitis*: This is most commonly associated with poor general health of the patient, such as uncontrolled diabetes, the chronically ill child, prolonged administration of wide-spectrum antibiotics, or early pregnancy. The white, lumpy discharge is frequently associated with a red, pruritic vagina.

5. *Trichomonal vaginitis*: This is unusual until puberty. The discharge is heavy, thick, pruritic and frothy.

6. *Pinworm vaginitis*: This is a very common cause of vaginal itching and discharge. The pinworm should be searched for in all cases of vaginal discharge, particularly in those patients with history of anal itching or excoriation of the perineum.

7. *Foreign body in the vagina*: This condition may cause a profuse, foul, and bloody discharge. A thorough, complete physical examination should reveal its presence.

8. *Streptococcal and diphtheritic vaginitis*: These infections may cause a bloody, foul, profuse, and purulent discharge. Culture of the organism is diagnostic, but gram stain of vaginal contents may be helpful.

9. *Other acute infections*: Typhoid and dysentery may have associated vaginal infection. Measles and other respiratory illnesses may cause a catarrhal discharge. Vesicles of chickenpox and herpes simplex may occur in the vulvovaginal region as on other mucous membranes.

10. *Pelvic malignancy*: Any type may produce a profuse, foul, sanguinous discharge. This is especially true of embryonal rhabdomyosarcoma (sarcoma botryoides) which may produce hemorrhagic grape-like masses projecting from the vulva. It frequently invades the bladder. It is more common in the first few years of life.

### Diagnosis of Vaginal Condition

A good physical examination is most important in establishing a diagnosis. Although a direct examination of the entire vaginal vault is desirable, this may be delayed for a few days in the absence of bloody discharge and only a partial examination be performed. A careful external examination with a good source of light will permit inspection of part, if not all, of the vaginal tract. A rectal examination should always be done because it may reveal the presence of vaginal foreign bodies as well as enlargement of internal genital organs.

A bloody discharge, except in the neonatal period, requires immediate diagnosis, under sedation if needed. In the absence of tumor or foreign body, it usually indicates a serious infection such as diphtheria or streptococcus. Gram stain may be diagnostic. Cultures should be taken.

A purulent discharge probably indicates gonorrhea. A gram stain is helpful but should be confirmed by culture because organisms of the *Mimae* group are indistinguishable from the gonococcus on a gram stained smear.<sup>3</sup>

If therapy does not produce prompt cessation of symptoms after four or five days, a more thorough and complete examination is indicated. One should not hesitate to sedate the youngster in order to perform a thorough and complete examination. Intramuscular paraldehyde 1/10 cc per pound is very effective for this purpose. In the event that examination of the cervix is needed, several common instruments may be used, such as the nasal speculum and infant proctoscope. The knee-chest position is recommended for this examination. Aspiration of the vaginal secretions for direct examination and culture is readily accomplished with a moistened glass or plastic medicine dropper. Smears, cultures, and biopsies may be taken with the usual instruments.

### Treatment

For nonspecific vaginitis or excessive physiological discharge, improvement in vulvovaginal hygiene is usually all that is needed. A simple, but effective method of douching is to place the child on her back in the bathtub with the lower extremities in the frog-leg position. By pouring warm tub water from a pitcher onto the now exposed genital area from a height of twelve to eighteen inches, an effective douche is performed. It is often best for the child to shower first and then douche with clean water. This eliminates from the douche soaps and detergents which may cause irritation.

If, after a few days of improved hygiene, symptoms persist, the specific organisms previously cultured on smear may be treated with systemic or local antibacterial agents. One of the most useful preparations is the nitrofurantoin urethral suppository which slips easily into the child's vagina. It may be prescribed once or twice daily for ten days. A very useful preparation in stubborn cases is Acquacort gel, containing hydrocortisone, tyrothricin, and phenylmercuric acetate. It is placed in the vagina nightly for twelve days with a multiple dose pliable applicator.

In the treatment of gonorrhea, streptococcal, or diphtheritic infections, procaine penicillin is the antibiotic of choice, intramuscularly. For gonorrhea a two-day course of therapy is sufficient; for streptococcus and diphtheria a ten-day course of treatment is recommended. The indications for use of diphtheria antitoxin are the same as for respiratory tract involvement.

*Trichomonas* is easily treated in standard fashion. Diiodohydroxyquin (Floraquin) and tricofuron are equally effective. A suppository is placed in the



vagina at bedtime for one month and again for ten days at the beginning of the next menstrual period.

Monilia responds to nystatin vaginal suppositories at bedtime. Therapy is continued for one month.

Pinworms are treated in the standard oral manner, usually with a piperazine preparation or with pyriminium pamoate. Local treatment is unnecessary.

Discharge accompanying generalized infection requires only good hygiene and therapy of the major underlying disease.

### Summary

Vaginal discharge of female children of all ages is rather common. Although many causes are possible, the most common cause is a nonspecific vaginitis. Pinworms, trauma, foreign bodies, and poor hygiene

frequently are predisposing factors. Correction of these conditions will remove the symptoms. Although complete vaginal examination is not usually necessary on the first visit to the office, persistence of symptoms or presence of a bloody or purulent discharge demands complete examination, culture (and biopsy if indicated) before further therapy is instituted.

*Martin Army Hospital*

### REFERENCES

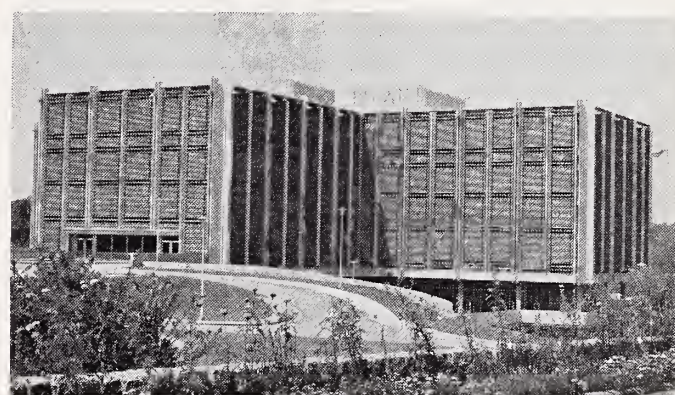
1. Nelson, W. E.: *Textbook of Pediatrics*, 7th Edition; Philadelphia, Pa., W. B. Saunders Company, 1959.
2. Altchek, A.: Vulvovaginal Irritation and Discharge in Children; *Surgical Clinics of N. Am.* Vol. 40, 4:1071, August 1960.
3. DeBord, G.: Species of the Tribes, Mimeae, Neisseria, and Streptococcae Which Confuse the Diagnosis of Gonorrhea by Smears; *J. Lab. and Clin. Med.* 28:710-714, 1943.

## THE NEW GEORGIA MENTAL HEALTH INSTITUTE

To educate, To seek, To treat—these are the goals of the new \$13 million Georgia Mental Health Institute located on a 33-acre site in northeast Atlanta. The Institute, under the administration of the Georgia Department of Public Health, includes a five-floor main administration building and six patient treatment cottages. Construction on two additional cottages, one for children and one for adolescents, will begin later this year. The two-story cottages—first level for out-patient care, second level for resident patients—have been assigned: five for adults, and one each for children, adolescents, and geriatric patients. When the Institute is initially opened, one of the six completed cottages will serve temporarily as an out-patient facility for children. When funds are available, an occupational therapy building will be constructed behind the main administration building.

### Georgia's Manpower Factory

Described as "Georgia's manpower factory," the Institute is designed to overcome Georgia's greatest problem in the field of mental health—lack of trained and highly qualified personnel to staff the state's present and future mental health facilities. The Institute will be operating under ideal conditions for a mental health facility. Its professional staff will consist not only of members of the Institute, but members of the Emory University School of Medicine as well. A cooperative agreement with the medical school will provide the Institute's comprehensive teaching and research programs. Professional direction will come from the medical school's Department of Psychiatry. Members of the Institute's professional staff who will come from outside Atlanta and the medical school will be given academic standing at the Emory University School of Medicine. In addition to the existing staff from Emory, the Institute is seeking professionals in many mental health disciplines. Some of the current needs are for psychiatrists, clinical psychologists, psychiatric nurses,



psychiatric social workers, occupational therapists, recreational therapists, psychology technicians, psychiatric aides, and clinical chaplains. Residency training is available in some disciplines; research and teaching programs will also offer additional career opportunities. Present plans include provision for training psychiatric residents, interns in clinical psychology and social workers, and to offer postgraduate training in psychiatric nursing. The training program for each professional discipline will be structured to reflect the previous academic and field experience of the candidate. The educational experience is expected to be equally divided between seminars and clinical work with patients.

The training program for psychiatrists will begin with 15 resident doctors. To become a certified psychiatrist, part of the doctor's training consists of three years of academic work and work with patients in an accredited educational institute such as the Georgia Mental Health Institute.

A similar number of resident doctors will be accepted in the second and third years, so that at the end of the third year there will be 45 doctors in training at the Institute. A three-year clinical training program in psychology is also being carried on at the Institute. Psychiatric nurses and social workers will be trained in a program slightly more than two years in length.



## Mental Health Institute / Continued

Director of the new Institute is Dr. Jesse F. Casey, who came out of retirement in Washington, D.C. to direct the new facility. Dr. Casey, formerly Director of Psychiatry for the Veterans Administration, has opened six mental health facilities in his lifetime. He emphasized the uniqueness of the Institute for out-patient activities—the cottages will provide facilities for patients who have been residents to become out-patients, while still maintaining the same professional personnel and building. The system will offer an ideal set-up for good continuity in training and treatment.

### A Broad Spectrum

Patients will be chosen from a broad spectrum, and specifically, for professional training purposes, and best possible patient treatment. Numbers of patients with similar problems would defeat the purpose of the facility—to offer as broad a field of training and research as possible for the professional staff. Dr. Casey emphasized that the Institute is not an emergency psychiatric center, nor is it equipped for medicine or surgery. The main building does house an infirmary, but patients with severe medical problems will be transferred to other facilities. Patients selected for admission will enter the Institute at the main building. Here they will be given a complete examination and then be assigned to one of the cottages. Each cottage will have a senior and junior psychiatrist and a complete nursing staff.

Patients, on either a voluntary or involuntary basis, will be received by referral from physicians only. This policy has been established so that patients will have a physician to return to upon completion of their treatment at the Institute. Patients will be treated by Institute staff members only; a private psychiatrist referring a patient to the Institute will not treat him at the Institute during the duration of his stay. The patient will, however, be referred back to the private psychiatrist after leaving the Institute.

### Payment and Implementation of Funds

A 1960 Georgia law provides that each patient must pay a specified amount for treatment, or, room, board and treatment. The payment differs at each institution in Georgia. At the Georgia Institute of Mental Health the payment will be \$12.39 per day, per in-patient for treatment, room and board; and \$6.56 per day, per out-patient for treatment only. The Georgia State Board of Health each year promulgates the figures for each state institution.

The funds collected for patient care at the Institute will be turned back into working funds for the Institute itself. They have not as yet been specifically earmarked for a particular purpose, such as treatment or research per se, but may be used for any number of things involving the operation of the Institute—maintenance, salaries, equipment, etc.

The physical plant of the Institute is one of which Georgia may be proud. The main administration building consists of the newest and finest in lay-out, equipment and materials. On the basement level is the service area for the entire complex—laundry; food services;

boiler room, with the latest in electronic equipment; barber shop; beauty salon; pharmacy, and heavy equipment vocational rehabilitation center.

The first floor consists of the executive, administrative and professional offices, as well as an auditorium. On the second floor patients will be admitted and processed. A bedroom, examining room and office, off the main admitting room, will house an M.D. who will be on 24 hour call. The remainder of this floor is occupied by patient rooms, treatment rooms, offices, conference rooms, and nursing station. Food will be served to patients in small, main dining rooms rather than in each individual room. On the third floor are more of the same facilities as are on the second floor; in addition, the second floor houses a data processing room; the “push button library,” which will be stocked with materials from the Emory Medical Library and books chosen by the Executive Officers of the Institute and personal contributions. The fourth and fifth floors are purposely not completed. These two floors will house the research area of the Institute, including an extensive audio-visual department. As each researcher joins the staff, he will choose his equipment and research set-up. A few research laboratories have already been included on the other floors.

### An Underground Tunnel

The main building is connected to all of the cottages by approximately one mile of underground tunnel. The walls of the tunnel are as yet unpainted, as they must settle for at least a year. It has been proposed by various members of the staff that perhaps an Art Club, composed of staff, personnel and patients, might be organized at the Institute and the tunnel utilized as an art gallery for the Institute. Each cottage is designated by its own color, the stair railings outside, and the door frames to the entrance of the tunnels being painted bright yellow, red, etc. The cottages' patient rooms will house from one to four patients each. The first floor is for out-patient treatment, and offices; the second floor for in-patient living quarters treatment, recreation and nursing station.

### Unique Feature

A unique feature of the main building is the “solar screen” a metal grillwork screen covering the building, which has become a standard feature for buildings in the South, as a temperature control device for heat from the sunlight. The cottages are almost cathedral-like in their appearance with their peaked roofs of opaque and stained glass.

Official dedication of the Institute is slated for November 18, 1965. Depending on equipment, the administration hopes to move in by November 1. This will provide time to orient the staff and organize the workings as much as possible before the initial, official opening.

Georgia's answer to the training of personnel for the treatment of the mentally ill is finally a reality. The ideal will be to attract the highest quality of staff who will be able to avail themselves of the finest in teaching and research facilities. The Georgia Institute of Mental Health should be the answer.





## The Role of the Sympathetic Nervous System In Sodium Excretion

**T**HE ROLE of the sympathetic nervous system in sodium excretion has received much attention in the research literature recently but has not been covered in the clinical literature. Clinical application is probably premature at the moment but this information could well become of considerable practical importance in the treatment of various types of edema as well as of great theoretical interest. The current status of the problem is reported below so that those who wish may follow its progress.

### Current Status

In 1952, Kriss, working in Harry Schroeder's laboratory found a report in the literature of 1924 in which sodium diuresis was produced in one kidney of a dog, but not in the opposite kidney, when a small vein was cut between that kidney and the homolateral adrenal gland. He and Schroeder after a number of experiments found that this effect could be duplicated by a homolateral subdiaphragmatic sympathectomy. This work has not been confirmed by another group recently. Little more was done on the subject until Barger showed that sympathetic blockade could produce sodium diuresis in dogs with experimental heart failure and Brod demonstrated this in patients with congestive heart failure.

Bradley found that infusions of norepinephrine would decrease sodium excretion in patients with Addison's Disease. Wagner learned that patients with autonomic insufficiency excrete sodium at supernormal rates. Gill, Mason and Bartter produced 50% to 300% greater saline diuresis with saline infusions in normal subjects with adrenergic blockade than without. This was through an effect independent of glomerular filtration rate. Sodium retention from adrenal steroids was reduced to about half after sympathetic blockade with guanethidine. Potassium excretion was also increased by the blockade. Gaffney and Braunwald's observation that guanethidine paradoxically reduces sodium excretion in patients with heart failure is probably because the failure is ag-

gravated by loss of catecholamines from the heart muscle.

Bartter has provoked edema and ascites in dogs by clamping the inferior vena cava above the hepatic vein. Gill found that pentolinium (Ansolysen) sympathetic blockade raised sodium excretion in such animals five to 20 times. Gill and Bartter gave guanethidine to individuals on a low (9 mEq/d) sodium intake and consequent renal conservation of sodium. Sodium loss increased four to six times over the predrug period.

The prompt retention of sodium in the upright position occurs even in patients with adrenal insufficiency and was thought to be related to the fall in glomerular filtration rate. However, Harrison, Reichsmann and Grant showed that sodium excretion could be raised almost to normal over a period of two to three hours by placing a cuff around the neck inflated to 28 mm. Hg. No one has known how to fit this study into the scheme of sodium excretion mechanisms. Could it be the sodium retention is caused by stimulation of the central sympathetic and that the cuff blocked the effect in some unknown way?

### A Discordant Note

A discordant note in all the evidence pointing to an adrenergic regulation of sodium excretion is an experiment performed by Carpenter, Holman, Ayers and Davis. They discovered that a kidney transplanted to the neck, with the opposite kidney removed, will still retain sodium sufficiently to cause edema and ascites when the inferior cava is clamped above the hepatic vein. This suggests that the sympathetic nervous system must work indirectly, possibly through stimulation of some humoral substance.

Mokotoff and Ross proved that the renal hemodynamic changes in heart failure are not produced by direct sympathetic stimulation of the kidney by giving patients a spinal anesthesia above the level of sympathetic innervation of the kidney. No change

occurred in RBF and GFR. Unfortunately, neither they nor we in similar experiments measured sodium excretion.

Thus, in summary, we see that adrenergic blockade can take precedence and reverse the sodium retention of (1) sodium restriction (an aldosterone phenomenon), (2) adrenal corticoids, (3) experimental heart failure and some cases of human heart failure, (4) inferior caval clamping above the hepatic vein and, (5) the upright position. Sodium excretion is increased in patients with autonomic insufficiency, and sodium retention is produced by infusion of norepinephrine in patients with Addison's Disease.

The fact that sympathetic blockade partially reverses the sodium retention in Bartter's inferior caval clamped dogs does not mean that the sympathetic nervous system is the *cause* of the sodium retention. It would have been interesting to have blocked the sympathetic nervous system in the dogs with the transplanted kidney to see if it would cause sodium diuresis. This, indeed, would have shown that the sympathetic blockade either works through some intrarenal connection or indirectly through release of some humoral substance.

The clinical and therapeutic implications of this work are exciting. One wonders if sympathectomy

affects hypertension partially through salt loss. The connection with the mechanism of sodium retention in heart failure is of great interest and the therapeutic possibilities are intriguing. In the latter, one must bear in mind that the sympathetic nervous system is of paramount importance in force of cardiac contraction, and blockade may work in two opposite directions in the salt retention of heart failure for this reason. Also, blockade may reduce cardiac output in upright patients by producing pooling of blood in dependent areas. Here, again, the diuretic effect of adrenergic blockade might be counterbalanced in the vertical position by changes in the cardiac output.

The cause of so-called "psychical edema" in tense women, especially those who work outside the home and direct the home as well, is not understood. One wonders if at least part of this may be autonomically influenced. Sympathetic blockade should be done experimentally bearing in mind the two effects on cardiac output mentioned above.

It appears that, while we are not ready for sympathetic blockade in edema in our practice or on the wards, we should watch further developments with interest.

Arthur J. Merrill, M.D.  
35 4th Street, N.E.  
Atlanta, Georgia 30309

*Bibliography furnished on request.*

## Georgia Physicians to Receive Increased Benefits In Newly Revised Life Insurance Program

THE MEDICAL ASSOCIATION of Georgia is pleased to announce to its membership the availability of the *newly revised* MAG group insurance program as underwritten by the Life Insurance Company of Georgia. This revised and improved coverage was the joint undertaking of the MAG Insurance and Economic Board and Life of Georgia—to provide increased coverage in line with the needs of today's physician. This revised plan has been approved by MAG Council and is based on the same three separate types of plans presently underwritten by Life of Georgia for members of MAG on a group basis.

### Increased Benefits

Elsewhere in this issue of *JMAG*, a detailed outline of the new, revised coverage is explained, but in short, the benefits have been increased with many options as to the amount of coverage for selective

individual choice by the physician. Please note that the three basic plans (1) term life insurance; (2) health and accident insurance; and (3) hospital and nurse catastrophic insurance, will be continued—but the physician may now choose certain benefit increases to fit his particular needs.

All physicians will receive detailed explanations of this excellent revision both through the mail and by personal visitation from Life of Georgia. It is most important that you give this new plan your full consideration, because it was designed by physicians for physicians through MAG. And it is available at group premium rates because you are a member of MAG.

The MAG Insurance and Economics Board highly recommends your interest in this revised MAG-Life of Georgia program—give it your time for study, as the program certainly merits your participation.



# Radiologists and Hospital Charges

**T**HE AMERICAN COLLEGE of Radiology has called attention to a new statement of policy on the relations between radiologists and the hospitals in which they practice. The new policy calls for an end to contracts under which a single charge to patients is made for radiology and then separated according to contractual agreement between radiologist and hospital. This ACR policy is to bring radiologists into conformity with the letter and the spirit of medical ethics and put radiologists on the same footing as other physicians on the hospital staff.

## In Accordance With Actions

This ACR policy statement is in complete accord with the previous actions of the AMA House of Delegates and the House's latest action on October 2-3, 1965, which stated: "Hospital-based medical

specialists are engaged in the practice of medicine. The fees for the services of such specialists should not be merged with hospital charges. The charges for the services of such specialists should be established, billed, and collected by the medical specialist in the same manner as are the fees of other physicians." The ACR statement is also in accord with actions on this same subject by the Medical Association of Georgia meeting May, 1965.

AMA notes that it will be most important that radiologists receive the full support of state and county medical societies in their efforts to make any necessary changes in arrangements with hospitals. Suffice it to say that the Medical Association of Georgia encourages this support by the entire profession and recommends cooperation of all component county medical societies.

## AMA House of Delegates Calls Special Meeting at Chicago

**A**T THE REQUEST of 37 Delegates of the American Medical Association House of Delegates, the AMA convened a special, called meeting of its 235 member House on October 2-3, 1965, Chicago. The specific call of the meeting was "to consider pertinent items relating to current problems incident to health care laws and pending legislation."

## Forty-three Resolutions

Some 43 resolutions submitted by Delegates were referred to a single House Reference Committee which heard 125 persons during seven and one-half hours of deliberation. Discussion included the legal and ethical aspects of physician participation under the new "Medicare" law (P.L. 89-97); certification of hospitals by HEW; reasonable, customary or usual fees; utilization review committees; options of compensation for physician's services; separation of professional fees from hospital charges, etc. Most of the discussion related to the yet-to-be-determined rules and regulations of P.L. 89-97 and questions of participation and non-participation with the Medicare law.

The AMA House in effect stated that the question of participation or non-participation was a matter for each individual physician to determine. AMA Legal Counsel stated that an individual physician, acting independently and not in concert with another, can lawfully refuse to accept patient beneficiaries under the program. Legal Counsel also stated, however, that physicians in groups, such as county and state medical societies, would be subject to the Sherman Antitrust laws if these groups took a non-participation stand.

## Physician Is Ethically Free

AMA Judicial Council pointed out that ethically a physician is free to select his patients, but this freedom may be circumscribed by overriding ethical considerations, namely: a physician should respond to a request for emergency treatment; a physician, once having taken a case, should not neglect the patient, nor should he withdraw from the case without giving notice sufficient to allow the patient to obtain another physician; that if a physician should decide not to participate in the Medicare program or decides to

limit his participation, he should so advise the patient in advance of the treatment; and a physician should not refuse to render medical service to any person, if as a result, such person will be unable to get necessary medical care.

More specifically, AMA Judicial Council also said that if after regulations are promulgated and the Medicare law becomes effective, the individual physician, acting independently and not in concert with others, finds it does tend to impair the free and complete exercise of medical judgement and skill or to cause a deterioration of the quality of medical care, the individual physician would be justified in not

participating, subject to the ethical limitations previously stated.

The House gave approval to the continuation of AMA advisory committees to HEW on P.L. 89-97 in the formulation of rules and regulations insofar as it helps achieve Medicine's objectives, but not to be confused with a change in basic AMA policy to modify and/or repeal P.L. 89-97. The AMA Board of Trustees was also given a vote of renewed confidence by the Delegates.

The House also emphasized unity of the profession—a unity of purpose and continued communication so that the entire profession may be well informed in the field of health care law and legislation.

## Diabetes Detection

**N**OVEMBER 15-20, 1965, has been designated by the American Diabetes Association as Diabetes Detection Week. The year-round effort to find the unknown diabetic individual is featured by the annual nationwide Diabetes Week during which a special attempt is made to screen as many persons as possible for diabetes mellitus. The Annual Detection Drive uncovers a significant number of persons with unknown diabetes. Equally important functions of Diabetes Detection Week are to educate the public about diabetes and to re-kindle the interest of all physicians in this important disease.

### Half Are Undiagnosed

A recent report indicates that there are about 3,156,000 diabetics in the United States. This is a national average of 9.8 cases in every 1,000 population. About half of these are undiagnosed. Approximately one of every 135 patients who come into a doctor's office is an unknown diabetic. To give the best performance for those under his care, every doctor can improve his service by detecting diabetes as early as possible. If a patient presents any of the following clinical features, the possibility of diabetes is considerably increased: (1) Family history of diabetes; (2) obesity; (3) transitory glycosuria or non-diagnostic hyperglycemia, especially during pregnancy, surgical procedures, trauma, emotional stress, myocardial infarction, cerebrovascular accident, or other types of stress such as acute hemorrhage, or following the administration of adrenal steroids; (4) women who have had large babies or have had abortions, premature labor, still-

births, or neonatal deaths; (5) individuals who were themselves large babies; and (6) otherwise unexplained neuropathy, retinopathy, nephropathy, coronary artery disease or peripheral vascular disease. To this group might be added the person who has been labeled as a suspect in a Diabetes Detection Drive.

### Important Testing

It is well known that a blood glucose determination is necessary for a diagnosis of diabetes mellitus. This determination should be done after a high carbohydrate meal unless the fasting blood sugar is high enough to allow a definite diagnosis. The two-hour post-prandial blood sugar is generally the most practical procedure for the screening of individuals suspected of having diabetes in ordinary medical practice. This should be followed usually by a glucose tolerance test when the post-prandial blood sugar does not yield a definite diagnosis. Other procedures such as the rapid intravenous glucose tolerance test, the intravenous sodium tolbutamide tolerance test, and the cortisone-glucose tolerance test are occasionally of additional value but are still of value primarily as research procedures.

It is hoped that every physician in the state will support the Georgia Diabetes Association and the local diabetes associations in their general objectives of professional education, patient education, education of the general public, case finding and research.

*Edwin C. Evans, M.D.  
1211 West Peachtree Street, N.E.  
Atlanta, Georgia 30309*



# AMERICAN MEDICAL ASSOCIATION

## EDUCATION AND RESEARCH FOUNDATION

### UNVEILS NEW INSTITUTE FOR BIOMEDICAL RESEARCH

The Biomedical Research Institute of the American Medical Association was created under the auspices of the AMA Education and Research Foundation (AMA-ERF) by the action of its Board of Directors: Drs. Raymond M. McKeown, President; Charles L. Hudson, Vice President; James Z. Appel, Secretary-Treasurer; Gerald D. Dorman; and George M. Fister, and endorsed by the House of Delegates at the June, 1963 Annual Meeting in Atlantic City, New Jersey. The Institute is a program of the Division of Scientific Activities. Dr. Hugh H. Hussey is Director of this Division. Dr. Roy E. Ritts, Jr., was appointed Director of the Institute in February 1964.

#### Objectives

The purpose of the Institute is to provide a privately supported basic research facility of excellence in which the investigator-member may devote his interests to his work without any other duties except as he may elect. As such, this activity is representative of the recognition, interest, and support given to basic research by the American physician.

#### Advisors and Consultants

The body empowered to suggest policies and staff for this new Institute is termed the Committee of Scientific Advisors to the Board of Directors of the AMA-ERF. This Committee will be composed of five to seven members who will serve for one-year renewable terms. They are authorized to elect their own chairman and submit names of new members. It is expected that this Committee will suggest areas and directions of research, including studies that might be unique or long-term as well as the names of men who would be interested in and capable of doing such investigation. In addition, they would act upon the names of investigators submitted to them by the administrative staff of the Institute.

A panel of consultants has been formed to advise the administrative staff and the Committee of Scientific Advisors on specific problems as they may arise.

#### Scope

Recognizing that biology is the study of the life processes, and that diseases are aberrations of these processes, the Institute is devoted to the support of fundamental inquiry into the life processes on all basic levels as conceived and directed by its members. It does not focus its attention on disease-oriented programs except as it may aid the individual scientist in his own research. There are no dictated research activities or applied research programs associated with the Institute. All investigation is originated and performed by its members. The major field of interest is on the intracellular processes. Therefore, research in the broadly defined areas of molecular biology, including biochemical genetics, fine structure and function, antibody synthesis,

experimental ecology, mechanisms of neuroexcitation, etc., would be examples of the Institute's interest.

#### Organization

The Institute is in the Division of Scientific Activities, one of six divisions of the Association. The Director of the Institute is empowered to act for the members and would do so through the Division Director to the Executive Vice President.

The Institute is composed of the following ranks which are proposed for individual scientists by the Director of the Institute and the Division Director to the Board of Directors.

The rank of *Member* is given to established or promising investigators who have demonstrated competence and originality in their investigation and who have made significant contributions to the body of scientific knowledge. The judgment of any investigator is then necessarily based on the content of his published works, not the number, and by recognition by the scientific community. Members are given tenure usually after one year of residence or, in exceptional cases, immediately on beginning residence.

*Associate Members* are appointed on the same general qualification as members but have less experience. It would be expected that the associate members have not reached their full potential when they are appointed but would as their experience increased. They are appointed with provisional tenure for an initial two-to-three-year period. Reappointments after this time carry full tenure at this rank. Promotions to membership will be considered annually after this time.

*Assistant Members* are appointed, renewable, for two-year periods on the basis of their promise with the expectation that advancement to higher ranks will normally follow. In exceptional situations, promotion to full membership will be made.

In all cases, appointments are based solely on the individual's accomplishments in research and not on other attributes such as teaching ability, administrative prowess, etc.

Other professional appointments, as research associates and postdoctoral fellows, will be made for one-year periods on the recommendations of members and associate members to the director.

Other appointments such as research assistants (technicians), etc., will be made as required by the Institute's staff.

#### Tenure

Since the Institute is not a university it is appropriate to define tenure even though the sense of this term is implicit to all. The Institute acknowledges the help of the American Association of University Professors in delineating this term. It has become necessary to alter it because the Institute, in following AMA policy, does not have a mandatory retirement age.



1. Institute professional staff shall have no administrative or teaching responsibilities other than those they may assume themselves. An annual budget and report and participation in weekly scientific seminars are the maximum required activities.

2. Institute professional staff shall be free from any external compulsion to publish to obviate the recording of trivia, dross and premature conclusions.

3. Institute professional staff shall be permitted sabbaticals and enough time (one to three months) off for contemplative study or research in other institutions.

4. Sabbaticals must be applied for in writing at least nine months in advance. A general plan of the member's activities is required. Such proposals as visiting professorships, research activities, preparation of scholarly tomes, during this time are encouraged. Full salaries are paid for pre-determined six-month sabbaticals. One-half salaries are paid for pre-determined twelve-month sabbaticals. If a previously agreed upon six-month sabbatical is extended to one year, no salary beyond the six-month period will be paid. Six-to-ten-month sabbaticals will be supported on a pre-arranged negotiation.

5. Honoraria: While outside activities (see section on privileges) are encouraged, the acceptance of fees or honoraria for these services by the professional staff is prohibited. Travel and living expenses incurred in these services may be accepted. Members and their staff receiving honoraria or remuneration in any form may return the fee, contribute it in their own name, the name of the giver, their alma mater, the AMA, or their chosen non-profit charity, to any non-profit, scientific or charitable organization.

6. Institute professional staff shall be provided with a retirement plan of reasonable substance, as outlined in the AMA booklet on insurance and retirement.

7. Institute professional staff shall be provided with the provision to continue their researches past the age of 65 with the individual's status to be reviewed solely with respect to his ability and productivity.

8. Institute professional staff shall be ranked and

salaried on the basis of their activities and accomplishments.

9. Institute professional staff shall be able to assemble a group about them devoted to their general area of activity; a member is not encouraged to build an institute within an institute, but reasonable expansion commensurate with his accomplishments should be encouraged. Should he choose, he may work completely alone.

### **Responsibilities of Membership**

1. To conduct fundamental inquiry into biological processes;

2. To continue his usual scientific productivity with detail to completeness and objectivity;

3. To prepare an annual budget and brief yearly report of his laboratory's activities; and

4. To participate in weekly seminars for the staff.

### **Privileges of Membership**

1. Ideal laboratory facilities and ancillary resources;

2. Tenure for members and associate members;

3. Retirement and health plans, sabbatical;

4. Opportunity for graduate fellows;

5. Freedom to accept university or governmental or other institutional duties, such as lecturing, visiting professorships, consulting, study sections, etc. No time restrictions are placed on this activity, other than that the laboratory's efforts shall not be unduly interrupted except in case of sabbaticals.

### **What the Institute Will Not Do**

1. Clinical investigation with private or indigent patients in private or public hospitals, clinics, or practices.

2. Render any medical services to patients.

3. Institute any form of graduate training leading to a degree.

4. Engage in synthesis of pharmaceuticals with the intent to patent, produce, or sell same. This does not mean that if on theoretical grounds a compound not existing, that would be useful to synthesize to test in the line of research in a particular laboratory, would be prohibited.

5. Dictated crash research.

## **FILMS AND LITERATURE ON CANCER AVAILABLE FROM LOCAL CANCER SOCIETY**

It has been truthfully stated that the most important factor in making a diagnosis is to think of the disease. With four times as many deaths being caused by cancer as by traffic accidents—and over 40% of them in the most productive years—21 to 64—it behooves all of us to be constantly aware of cancer as a possible diagnosis.

To help Georgia physicians keep up to date and aware of cancer as a diagnosis possibility, the American Cancer Society, Georgia Division, has teaching films, monography and many other aids available. They are "yours for the asking" without charge.

Breast Cancer, Problems of Early Diagnosis—  
monograph and film.

Uterine Cancer—Problems of Early Diagnosis—  
—monographs and film.

Lung Cancer—Problems of Early Diagnosis—  
monographs and film.

Oral Cancer—Problem of Early Diagnosis—  
monographs and film.

Routine Pelvic Examination—Film.

After Mastectomy—booklet and film.

If you are worrying about a program for your next hospital staff meeting or County Medical Society Meeting, the Cancer Society will gladly furnish you a program on cancer—a speaker, and/or films. Just write American Cancer Society, Georgia Division, 2025 Peachtree Road, Atlanta, Ga. 30309.



**FOR YOUR  
ELDERLY  
ARTHRITIC  
PATIENTS...**



an effective  
**GERIATRIC**  
antiarthritic  
with

**REASSURING SAFETY FACTORS**

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention...the enteric coating assures gastric tolerance...and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

**Pabalate-SF**

In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

—the new, convenient way to prescribe  
**PABALATE-SODIUM FREE**

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA



## MEDICARE AND COMMUNICATION

ON OCTOBER 1st, the Medical Association of Georgia had a delegation composed of me, along with six others, to attend the American Medical Association "Orientation Conference on Medicare," held in Chicago at the LaSalle Hotel. The panelists at this conference included the AMA Advisory Committee to the Department of Health, Education and Welfare along with John W. Gardner, Secretary of the Department; Phillip R. Lee, M.D., Deputy Assistant Secretary, Health and Medical Affairs HEW; Arthur E. Hess, Director, Bureau Disability and Health Insurance, Social Security Administration; plus representatives from Blue Cross, Blue Shield, the Health Insurance Industry and the American Hospital Association. This was a well-attended Conference—estimated at 500 to 600.

### Called Meeting

The following two days, we were joined by two others for the special, called meeting of the AMA House of Delegates. We moved to the Palmer House for this meeting which had been called on petition of 37 members, about 15%, of the House. This meeting could have been called on petition of 25 members representing one-third of the States. This is mentioned here to bring out the fact that the AMA is a democratic organization.

I will not try to make a report here on what took place at the conference or upon the action of the House of Delegates. Space does not permit and you should have been fully informed through the *MAG State and County Officers News Letter* which goes to your County Officers, so they in turn can inform you. However, your best source of information is the *AMA News* which is published weekly. The above sources will have been available before this is printed.

The House of Delegates Meeting pre-empted the time set for a planned AMA National Conference on Medical Ethics and Professionalism, and in so doing upset the plans for a similar state level conference by MAG. It is my understanding that the AMA Ethics Conference will be rescheduled later and, if so, we will pick up our plans for a state conference and probably combine it with a briefing on Medicare.

One of the complaints voiced most frequently at the House of Delegates Meeting was that the "rank

and file" didn't know what was going on. It undoubtedly is true that even in the Department of Health, Education and Welfare there is much confusion and uncertainty concerning regulations; who will be the fiscal intermediaries and what state agency or agencies will administer the program.

Without going into detail here, let me assure you that the Advisory and Technical Committees of the AMA will be doing all they can to help mold regulations that will make the program less difficult to live with.

### Teletype Communication

In the meantime, the AMA Headquarters is tied to the MAG Headquarters by a TWX Communication System and as information comes through it will be passed on to your officers whenever indicated. In addition, whenever any information is deemed of sufficient importance, the *Officers News Letter* will convey it to the county officers who in turn should then communicate the information to their society members.

How many of you make it a habit to read the *AMA News*? I admit, readily, that with the tremendous volume of mail coming over your desk, it is mighty easy to toss into the waste basket anything other than first-class mail.

Don't let that happen to the *AMA News* or to anything from MAG Headquarters. The *AMA News* is your weekly medical newspaper and is your means of being kept promptly informed about what is going on. Make it a habit to read it regularly. A few minutes each week will certainly make you more knowledgeable and put you in a better position to answer questions that may be put to you and also to take necessary action to check undesirable trends.

Don't hesitate to ask your Councilor or me or the other officers any question you may have in mind. We may not always be able to provide all the answers, but you will find us willing and anxious to tell you all we can.

Let's all read our mail and keep those lines of communication open.

George H. Alexander, M.D.  
President, Medical Association of Georgia



*Which  
Member of the Wedding  
will have  
Biliary Dysfunction?*

All of them, possibly.

Patients approaching middle age, as well as pregnant women who complain of constipation, belching, and flatulence, with no evidence of organic disease may be suffering from functional disturbance of the biliary tract.

Often, these basic disturbances can be corrected by a single convenient and effective medication: Neocholan.

Neocholan is more than a laxative. It combines all the ingredients for the total management of functional biliary stasis in one tablet. Dehydrocholic acid stimulates the production of thin, free-flowing bile. Bile salts promote better digestion to absorb fats and fat-soluble vitamins, and they tend to prevent chronic constipation by maintaining intestinal tone and normal peristalsis. Phenobarbital and homatropine methyl bromide relax intestinal spasm and insure unobstructed passage of bile and pancreatic juice into the duodenum.

Neocholan is contraindicated in patients with glaucoma. Use cautiously in elderly patients with urinary retention and reduce dosage if blurring of vision, increase in pulse rate, or distressing dryness of the mouth result.

Each tablet contains Dehydrocholic Acid: 250 mg. ( $3\frac{3}{4}$  gr.); Bile Extract (Porcine): 15 mg. ( $\frac{1}{4}$  gr.); Phenobarbital: 8.0 mg. ( $\frac{1}{8}$  gr.) (Warning: May be habit forming); Homatropine Methyl Bromide: 1.2 mg. ( $\frac{1}{50}$  gr.).

**NEOCHOLAN®**



**PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis.







*Look, Doctor, what he needs is a shot of penicillin.*

Maybe. Maybe not. In any case, he needs something to control his cough.

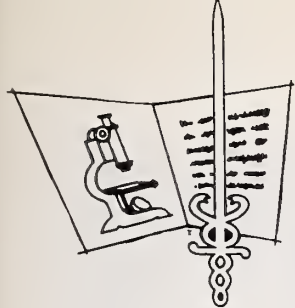
If it's the useless, exhausting type of cough that often accompanies respiratory infection or allergy, you can provide prompt relief with Novahistine DH. Its decongestant-antitussive action controls frequency and intensity of cough spasms without abolishing cough reflex. And the fresh, grape flavor of Novahistine DH appeals to children and adults alike. When your diagnosis is bronchitis, complicated by thick tenacious exudates, Novahistine Expectorant is particularly useful. It not only provides decongestive action and controls the cough, but also encourages expectoration, thus easing bronchial obstruction.

Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that drowsiness may result. Continuous dosage over an extended period is contraindicated since codeine phosphate may cause addiction.

Each 5 ml. teaspoonful of Novahistine DH contains phenylephrine hydrochloride, 10 mg., chlorpheniramine maleate, 2 mg., codeine phosphate, 10 mg. (Warning: may be habit forming), chloroform (approx.), 13.5 mg., l-menthol, 1 mg., Alcohol 5%. Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl guaiacolate, 100 mg.

**NOVAHISTINE® DH**  
**NOVAHISTINE® EXPECTORANT**





## DO IT YOURSELF PAP SMEAR KIT

**Beware—Only 72% Accurate**

**F**OR SOME TIME we have been hearing of the Davis "Do It Yourself" Pap Smear Kit. The American Cancer Society has made an extensive survey of this modality, and is even now continuing this study in conjunction with the Cancer Control Division of the U. S. Public Health Service. One facet of this investigation was carried out by Dr. W. A. D. Anderson of Miami. The Davis Kit consists of a glass syringe containing liquid with which the patient irrigates the vagina and collects the irrigating fluid. The liquid, while harmless to the vagina, preserves the aspirated cells. These are examined and determination made as to whether there are any malignant cells present. It was thought that this might be a great method for mass survey of our population.

### Investigation for Eighteen Months

Investigation was done on all the female patients coming to Jackson Memorial Hospital for pelvic examinations over an 18 months period of time. A cervical scrape was obtained on each patient and the patient given a vaginal aspiration kit (Davis), asked to take this home, read the directions, perform the test and return the kit. A total of 4,774 correlated cases with 100 cases of various genital cancer were studied. The cervical scrape gave 95.5% accuracy while the vaginal irrigation yielded but 72.7% accuracy. This has been a great disappointment. In addition, in regard to the methodology, to process 100 vaginal irrigation kits required seven more man hours than to process 100 scrape smears. To screen and interpret the vaginal irrigation kits also required

A. H. Letton, M.D., *Atlanta*

30% more time than to screen and determine the cervical scrape.

It cannot be denied that the best protection securable against cervical cancer is a physician examination including a scraping directly from the cervix. In Anderson's survey of a population of low social economic status with a prevalent rate of cancer of the cervix of 18 to 20 per thousand examined women, the irrigation kit detected only 14 per thousand, which, while it was remarkable, was not ideal. In an attempt to pick up these four to six cases per thousand which were missed, they estimated that they would have to call in for scrape 560 patients per thousand which is hardly acceptable from a practical standpoint since this is more than half the women. It may be concluded however, from this survey, that when a physician examination can *not* be made available, the self-administered irrigation kit may be used as a *preliminary* screening method; *but a note of caution must be inserted.*

### Kit Offered by Insurance Companies

This irrigation kit is being offered by various insurance companies to their policyholders. We want to let you, the physicians of Georgia, have this information so that you can know and evaluate the results of this test. It should be stressed that at best, only 72% accuracy was obtained from these tests, and a negative by this method is not necessarily negative.

*340 Boulevard, N.E.*

Approved by the Professional Education Committee, Georgia Division, ACS.

## MEDICAL EDUCATION ANNIVERSARY HIGHLIGHTS CLINICAL CONVENTION

The 200th anniversary of medical education in the United States is being observed in Philadelphia as the American Medical Association holds its 19th Clinical Convention there November 28-December 1.

The convention is being held in cooperation with the bicentennial observance of the nation's oldest medical school, the University of Pennsylvania School of Medicine.

Physicians and their families will be able to participate in ceremonies observing the school's founding. They also will have opportunities to visit other parts of historic Philadelphia.

Independence Hall, the Liberty Bell, Betsy Ross' house and the old Custom House are among many important historical sites that make Philadelphia one of America's most interesting cities to visit.





## "All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet dis-

integration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.







## PREVENTION OF BACTERIAL ENDOCARDITIS

Samuel P. Tillman, M.D., *Statesboro*

THE efficacy of using antibiotics to prevent endocarditis and endarteritis in patients who have rheumatic valvular disease and various types of congenital cardiovascular disease, and who undergo operative procedures has been well established. Transitory bacteremia may result from dental extractions, oral surgical procedures and manipulation of periodontal tissues, tonsillectomies, bronchoscopy, operative procedures and instrumentation of the genitourinary tract, and may possibly occur following cardiac catheterization, sigmoidoscopy, childbirth and surgery of the lower intestinal tract.

### Can Be Significant

Okell and Elliott observed a transient bacteremia following dental extraction in 72% of patients with septic mouths and in 32% of subjects without obvious infection of the oral cavity. These brief bacteremias in the normal individual are of no significance; however, in persons with cardiovascular abnormalities, the microorganisms may localize about the endocardial defect and set up a bacterial endocarditis. The proper use of antibiotics may prevent the bacteremia or reduce its magnitude and duration should it occur, and also eradicate bacteria that may implant on heart valves before a vegetation is formed.

The *Streptococcus viridans* is the common organism found in infected tonsils and dental abscesses and is responsible for the preponderance of endocarditis following tonsillectomies and dental extractions. The most common causative organism following genito-urinary procedures, surgery of the lower GI tract and childbirth is the penicillin-resistant enterococcus. Various other gram negative bacteria and staphylococci have been incriminated following surgical procedures. One should consider the location of the operative procedures or instrumentation in his selection of the antibiotics to use in preventing endocarditis. Broad-spectrum antibiotics are not as reliable in eradicating bacterial implants and are generally not recommended. Sulfonamides are not satisfactory.

Penicillin is the proper drug to use with dental procedures, oral surgery and bronchoscopy. There is disagreement regarding use of antibiotics for

several days before such procedures are to be carried out. Such pre-treatment with penicillin is not likely to sterilize the involved area and could possibly lead to replacing of the usual sensitive bacteria in the upper respiratory tract by penicillin-resistant strains. There is *no* disagreement regarding the use of penicillin immediately before and following these procedures. Varying dosages and duration of therapy with penicillin have been recommended by different clinicians. The American Heart Association has recommended the following schedule for procedures involving the upper respiratory tract, mouth and nasal pharynx:

On the day of the procedure the patient should receive 600,000 units of Procaine penicillin supplemented by 600,000 units of crystalline penicillin intramuscularly one or two hours before the procedure. Six hundred thousand units of Procaine penicillin should be given intramuscularly each day for two days following the procedure. The only contraindication to the above regimen is penicillin sensitivity. Erythromycin, 1 Gm. daily in divided doses, for adults and older children, or 20 mg. per pound for younger children, would then be the drug of choice. The total dose should not exceed 1 Gm. per day.

Penicillin combined with streptomycin is recommended in those undergoing instrumentation or surgery of the GU tract, surgery of the lower GI tract and childbirth. The same penicillin regimen as outlined above should be used in combination with streptomycin, 1 or 2 Gms. intramuscularly on the day of the procedure and for each of two days following the procedure. In children streptomycin may be given in a dosage of 50 mg./kg., not to exceed 1 Gm. per day. In those sensitive to penicillin, erythromycin and streptomycin or a broad-spectrum antibiotic with streptomycin may be used, although there is little information available as to their effectiveness in preventing endocarditis due to enterococci.

302 Donehoo St.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.



DECATUR  
FEDERAL  
NORTH



In Dynamic DeKalb . . .

The Focal Point for Professional People

## DECATUR FEDERAL NORTH

Church and Barry Streets—Adjacent to Decatur Federal Building

Modern in Every Respect—Radiological Department; Pathological Laboratory; EEG Unit; Physiotherapy Unit; Unique Electronic Computer Billing Service; Radio-Controlled Answering Service; Medical Secretarial Service; Plus Many Other Appealing Features and AMPLE PARKING

Now Leasing for Occupancy in Early 1966

**Buck Bothwell, W. P. Tatum Company**, exclusive agent

Decatur Federal Building—373-5716



Another Healthy  
Addition to a  
Growing Community





## SOCIAL SECURITY FOR PHYSICIANS: A CONTINUATION\*

Mr. Francis Shackelford, *Atlanta*

MANY SELF-EMPLOYED doctors of medicine are asking questions about the coverage of, the cost of, and prerequisites to, and the benefits to be gained from the 1965 Amendments to the Social Security Act. The purpose of this article, which supplements the one in the Legal Page of the September issue of the *Journal*, is to answer in part some of these questions.

## How Much Social Security Tax Must Be Paid?

Social Security taxes are paid by self-employed persons at the same time that their federal final income tax returns for the year are due, i.e. April 15 of the following year. To offset the new across-the-board increase in all monthly benefits, the 1965 Amendments provided for an increase in tax revenue by raising the maximum amount on which Social Security taxes are paid (\$4,800 to \$6,600, after 1965) and also by raising the Social Security tax rate. Since the Social Security tax rate now includes the hospital tax for Medicare (the benefits of which are not discussed herein), the following table includes that new tax in computing the total that must be paid by a self-employed doctor who reports the maximum earnings allowed:

Year	Old Age, Survivors and Disability Tax Rate %	Hospital Tax Rate %	Total %	Amount of Tax
1965	5.4	.00	5.40	\$259.20
1966	5.8	.35	6.15	\$405.90
1973-75	7.0	.55	7.55	\$498.30
1987 and after	7.0	.8	7.8	\$514.80

Doctors who have income from current part-time employment covered by Social Security may save money on Social Security taxes because (1) the employee tax is calculated before the tax on self-employment income and (2) the employee tax rate is lower, 3.625% rather than 5.4%. One tax-planning idea for doctors is the creation of employment

on a part-time basis providing all or part of covered income.

The benefits of Social Security will not accrue unless and until payment of the tax has been made for the minimal number of calendar quarters. Consequently, for example, if one pays the tax for four years but needs credit for four and a half years of payments, there will be no benefits and no return of the taxes paid.

One who is a self-employed physician gets four quarters of credit for each year in which his net earnings from self-employment are \$400 or more. A doctor who is an employee may get a quarter of credit for each calendar quarter in which he is paid wages of \$50 or more. Many doctors will be able to claim Social Security credit for other work that was covered by Social Security before 1965. A doctor who was in the military service of the United States between September 15, 1940, and December 31, 1965, may get Social Security credit for active duty spent, in most cases. Since the end of 1956, military service has been covered by the law in the same way as other kinds of employment.

The number of quarters needed for benefits is divided mainly into two groups, best illustrated by the following:

(1) *For disability benefits*, credit for at least five years of work in the ten year period ending when the taxpayer becomes disabled is needed. The earliest year in which many doctors could claim these benefits will be 1970 and even then only if they have five continuous years of reported Social Security-covered income.

(2) *For retirement and survivors benefits*, the following table shows the number of quarters needed:

If one reaches age 65 (62 for women) or dies in	He will need credit for
1965	3½ years
1971	5
1991 (or later)	10

Note that a doctor who becomes 65 in 1965 and has no previous coverage will have to keep working until

\* See "Social Security for Physicians" by John L. Moore, Jr. in the September, 1965 Issue of the *Journal of the Medical Association of Georgia*, Vol. 54, p. 314.

some time in 1968 before he attains a fully insured status.

The doctor, who is now required to pay the Social Security tax, may rely on two different kinds of benefits: (1) old age insurance benefits are payable when he reaches 65 (or at age 62 if he is willing to take a reduced amount) for months in which he is retired or doing little or no work; (2) disability insurance benefits will be paid to one under 65 beginning with the seventh month of disability. In planning for the security of his family, the doctor can rely on the payment of tax free benefits to his wife and children. When the doctor is entitled to old age or disability insurance, the following relatives may be recipients of Social Security payments: his wife at age 65 (or with reductions at age 62); his wife under age 62 if she has in her care an unmarried child under 18; his unmarried children under 18 or under 22 if the child is attending school full time; his child over 18 if the child became disabled before reaching age 18 and has been disabled ever since. In the event of the doctor's death, the same categories of relatives may receive benefits and, in addition, dependent parents over 62 are eligible if the doctor has been contributing at least 50% of their support at the time of his death. Furthermore, a lump-sum death benefit, ranging from \$132 to \$255, is payable at the doctor's death in addition to any monthly benefits.

How Much Are the Benefit Payments?

Many people have assumed that most doctors will be able to claim the maximum benefit payable under Social Security but this is largely inaccurate. For many years no one who retires at age 65 will be eligible for the \$168 monthly benefit maximum (or \$368 family maximum) because benefits are based on "average monthly wage" on which Social Security tax is paid, and many doctors will have little or no such income to report for the years 1951 to 1965. Doctors, unlike lawyers and other professionals who were given coverage earlier, were not given a new starting date from which to determine their average monthly wage, and consequently, it will take longer to earn maximum benefits. Consequently, in the table above doctors who will retire in the next five years

will probably find themselves in the \$1,800 column and few will be eligible for the maximum benefits (under the \$6,600 column) until the latter part of the century.

Average yearly earnings after 1950	\$1,800	\$4,200	\$6,600
Retirement at 65			
Disability benefits	\$ 78.20	\$124.20	\$168.00
Retirement at 62	62.60	99.40	134.40
Wife's benefit at 65 or with child in her care	39.10	62.10	84.00
Widow age 62 or over	64.60	102.50	138.60
Widow at 60, no child	56.00	88.90	120.20
Widow under 62 and 1 child	117.40	186.40	252.00
Widow under 62 and 2 children	120.00	279.60	368.00
One surviving child	58.70	93.20	126.00
Maximum family payment	120.00	280.80	368.00
Lump-sum payment	234.60	255.00	255.00

One more factor should be mentioned regarding the benefit payments one may expect: the doctor between ages 65 and 72 who continues to work. It is not necessary to retire completely to get benefits; but one's Social Security check may be affected by total earnings and the number of months he works. If one earns no more than \$125 a month or \$1,500 a year, he will be entitled to full benefits. If he works throughout the year and earns more than \$1,500, \$1 in benefits will be withheld for each \$2 earned between \$1,500 and \$2,700. For every \$1 that he earns over \$2,700, \$1 in benefits will be withheld. After age 72, earnings do not affect benefit payments.

Conclusion

Now that Social Security is a matter of fact for doctors, readers of this page should not neglect it in assessing their financial commitments or expectancies. Although the benefits are not always overwhelming, it should be remembered that they are tax free. As President Eisenhower said:

"The (Social Security) system is not intended as a substitute for private savings, pension plans and insurance protection. It is rather intended as a foundation upon which these other forms of protection can be soundly built."

Suite 1220  
C & S Bank Building

Prepared at the request of The Medical Association of Georgia. Mr. Shackelford is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

"CIRCUIT COURSE" POSTGRADUATE EDUCATION  
TO BE PRESENTED IN SIX CITIES THROUGHOUT GEORGIA

The Medical Association of Georgia through its Medical Education Board is proud to announce the "1965-66 Georgia Circuit Courses"—consisting of six postgraduate symposia for physicians at afternoon and

evening sessions, one day each month, December through May, in local areas throughout the state.

Sponsored by the Medical College of Georgia, the Georgia Academy of General Practice and the MAG,



this six course series will be held in each one of six Georgia cities. These cities include: Waycross, Moultrie, Dublin, Toccoa, Dalton and Thomaston.

Course subjects to be presented in each series are: Arthritis; Care of the Acutely Injured Patient; Optic, Neurological and Medical Disorders; Problems in Reproductivity and Infant Care; Cardiovascular Disease; and Renal and Urinary Tract Diseases.

### The Best of Postgraduate Education

This series of courses is the best of postgraduate education brought to the locale of the practicing physician for his convenience. It is a tremendous effort in continuing education planning to cover the state with excellent one-day-a-month courses designed to fit a doctor's practice problems.

Certainly the Medical College of Georgia Department of Continuing Education deserves commendation for arranging this "circuit course" program as do the other organizations supporting this concept of bringing scientific advancement to the practitioner on his home grounds.

Each one-day program begins at 2.00 p.m. and con-

tains four and one-half hours of instruction, followed by a dinner at 7:00 p.m. The courses are planned for both the generalist and the specialist alike and are GAGP approved for Category I credit.

Courses begin and will be held as follows (*first month's course listed only*):

Wayscross/Memorial Hospital—December 7—Arthritis

Moultrie/Colquitt Hotel—December 8—Arthritis

Dublin/Veterans Administration Center Hospital—

December 9—Arthritis

Toccoa/Georgia Baptist Assembly Grounds—December 14—Cardiovascular Disease

Dalton/Hamilton Memorial Hospital—December 15—Cardiovascular Disease

Thomaston/Upson County Health Building—December 16—Cardiovascular Disease

For further information and registration data write: Department of Continuing Education, Medical College of Georgia, Augusta, Georgia 30902. In summary, the word on these "Circuit Courses" is—they have been planned and arranged for the practitioner, and MAG strongly urges all physicians to participate in this most important postgraduate educational activity for better patient care in Georgia.

## AMA CLINICAL CONVENTION IS THE ANSWER FOR BUSY PHYSICIAN

THE AMERICAN PHYSICIAN is well aware that he must keep abreast of new findings in therapy and research to be able to provide the best possible care for his patients.

He must know about new drugs and their uses and possible side effects. He must know about new techniques of surgery. He must know of the promising leads toward solution of now baffling physical ills. And he must know of the sometimes small but often important new successes in finding better ways to treat the already treatable diseases.

### Physician Must Learn

There's no argument about the premise that the physician must keep learning. The problem is how. With the average American physician now working a 58-hour week, and many putting in hours far above the average, how can the physician find the time to study and keep abreast?

One of the most compact methods of checking up on new developments is to attend the annual clinical convention of the American Medical Association. The program of this convention is designed primarily for the man in practice. The speakers will read papers that bring to the man in practice the latest findings of others in his area.

This year the clinical convention will be held in my home state of Pennsylvania, November 28-December 1, in Philadelphia.

### Scientific Program

The Philadelphia meeting offers an excellent scientific program. Topics of wide interest will be discussed by outstanding teachers. All of the various sessions and workshops will contribute to the continuing education of the practicing physician.

Particularly noteworthy are the postgraduate courses in gynecology and obstetrics and in cardiovascular therapeutics, consisting of two series of comprehensive lectures.

Other sessions will be devoted to timely subjects, followed by question-and-answer or discussion periods. Fireside conferences and breakfast roundtables will provide further time for informal discussion.

It promises to be a stimulating four days, worthy of the busy physician's time. I urge every physician to take advantage of the educational opportunity represented by the clinical convention.

*James Z. Appel, M.D.*

*President, American Medical Association*





## An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

**Indications:** 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

**Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

**Precautions:** Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may

# Miltown® (meprobamate)

possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

**Side effects:** Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very

rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

**Usual adult dosage:** One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

**Supplied:** In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

*Before prescribing, consult package circular.*

**WALLACE LABORATORIES**  
Cranbury, N.J.

CM-5761





## ULTRA, SHORT-TERM PSYCHOTHERAPY

M. B. Sell, M.D., *Augusta*

IT HAS BEEN found that one visit to someone interested in a family's mental health can be very therapeutic.

### A Technique

A technique has been developed at Eugene Talmadge Memorial Hospital for not only screening patients for the In-Patient Service but also attempting to bring about a change in the patient and his family in one or two visits. The patient is seen first for about 30 minutes and an attempt is made to define the immediate problem. The rest of the family is then brought into the interview situation for about an hour. During this time several things are attempted. (1) Get the family to begin communicating with one another. (2) Have them discuss the immediate problem and its probable cause and their different ideas as to a solution. (3) Actively participate yourself in offering practical suggestions as to a solution and then get their reactions. Later interviews with the family may be beneficial in identifying past situations which are analogous to the present.

When this technique was used, it was found that a significant number of people were helped to the

extent that they did not need in-patient admission even though they had been given an admission date.

### Communication

Other psychiatrically oriented professionals, such as general practitioners, internists, pediatricians, nurses and ministers can make use of this type of counseling. Chronic, long-standing situations are avoided; however, the counselor should not let himself be manipulated into "taking sides." He should, at all times, foster and stimulate communication between different members of the family. This should be his main goal.

This method of short-term treatment is particularly valuable when seeing a husband and wife with marital difficulties, and teenagers who are displaying normal teenage rebellion.

A psychiatrist should be asked to see acutely disturbed patients, those who are suicidal and those who have chronic, disabling problems which the counselor does not feel competent to manage.

*Eugene Talmadge Memorial Hospital*

Prepared at the request of the Sub-Committee on Mental Health of the Medical Association of Georgia.

## WIDE RANGE OF TOPICS AT SPORTS CONFERENCE

Management of head, neck and knee injuries will be among the main topics at the Seventh National Conference on the Medical Aspects of Sports, Sunday, November 28, in Philadelphia.

The day-long conference will be in conjunction with the AMA clinical convention. The conference promises to be of wide interest to physicians, especially those serving as high school or college team physicians.

Other featured topics: weight control in wrestling, estimation of the athlete's readiness for sports, and help for the atypical athlete in finding a place in sports.

Knee injuries, the most prevalent type in athletics, will get their due attention in evening sessions. Particular emphasis will be given to knee ligament injuries.

Indiscriminate efforts to achieve or maintain a certain weight to meet wrestling classifications has long been a problem. At the request of the National Federation of

High School Athletic Associations, the AMA is sponsoring a special symposium during the conference regarding clinical estimation of desirable body weight. Papers will focus on the type of physical stress inherent in wrestling.

### Head and Neck Injuries

Recognition and management of head and neck injuries will be a Conference symposium topic, and will be discussed by widely known medical authorities. These include E. S. Gurdjian, M.D., a Detroit neurosurgeon; Gerald A. O'Connor, M.D., director of sports medicine at the University of Michigan Medical Center; Martin E. Blazina, M.D., Los Angeles, the UCLA team physician and an orthopedic surgeon, and Gordon van den Noort, M.D., Bryn Mawr, Pa., president of American College of Neurosurgeons.



## DEATHS

JOSEPH COLQUITT LOGAN, 85, Plains physician for 63 years and mayor of his town since 1954, died August 17, 1965, at the Americus and Sumter County Hospital after a short illness.

Dr. Logan had received many and varied honors during his long career of distinguished service.

Several years ago he was named General Practitioner of the Year by the Medical Association of Georgia, and also was voted a lifetime membership in the American Academy of General Practice.

He was also a Fellow in the American Medical Association, a member of the Southern Medical Association, Medical Association of Georgia, Sumter County Medical Society, and listed in *Who's Who in American Medicine*.

He recently was honored on the occasion of his 50th year in Masonry by M. B. Council Lodge 95 of Masons, and he also held a 50-year certificate of service from the Medical Association of Georgia, its having been presented in special ceremonies in 1952.

At the time of his death Dr. Logan had served as chairman of the board of stewards for 40 years. For 35 years he also taught the Dr. J. C. Logan Bible Class at Plains Methodist.

Survivors, in addition to the widow, include one brother, Howard Logan, of Plains; two sisters, Mrs. Rosa L. Brown, Montgomery, Ala., and Mrs. Lennie Baynes, Decatur; also a number of nieces and nephews.

CLARENCE ADAIR RHODES, Atlanta pediatrician since 1911, died October 10, 1965.

Dr. Rhodes was the first pediatrician to serve on the staff of Grady Memorial Hospital. He also served on the staffs of the Crawford W. Long Hospital and St. Joseph's Infirmary.

He was a native of Rockingham County, Va., and was graduated from Randolph-Macon College and the Johns Hopkins School of Medicine. He was a member of the First Methodist Church, the American Medical Association and the Georgia State and Fulton County Medical Societies.

Survivors include his wife, the former Agnes Plummer; daughter, Mrs. Ellen Smith, Atlanta, and a brother, Boyd E. Rhodes, Wilmington, Calif.

ALLEN I. ROBBINS, 46, Homerville physician, died unexpectedly in Clinch Memorial Hospital July 24, 1965.

A native of Conway, Ark., he served two years in the U.S. Navy before moving to Homerville 18 years ago for the practice of medicine.

Dr. Robbins was a member of the First Baptist Church, and had served as chairman of the Board of Deacons. He was president of the Lake Verne Hunting and Fishing Club, president of the Clinch Athletic Boosters Club, a past president of the Lions Club, a

Mason, and had coached the Midget football team at Homerville Elementary School for the past ten years.

He was serving on the Clinch County Board of Health, was a member of the South Georgia Medical Society, the American Medical Association, and was a charter member of the American Academy of General Practice.

Survivors include his wife, Mrs. Ann Pittard Robbins; two sons, Allen I. Robbins, Jr., and Charlie Robbins both of Homerville; two daughters, Miss Bebe Robbins and Miss Jan Robbins, both of Homerville; four brothers, Wellington F. Robbins and Dr. Jo S. Robbins of Conway, Ark.; Stanley Robbins of West Memphis, Tenn., and Col. Frank Robbins of Birmingham, Ala.

## COUNTY MEDICAL SOCIETIES

TIFT COUNTY MEDICAL SOCIETY recently honored Mrs. Paul Lucas, founder of the Allied Medical Careers Club at Tift County High School and advisor to the group since its founding. Morris Davis, M.D., President of the Society presented Mrs. Lucas a silver tray at the club's meeting. Also present at the meeting was Mrs. Louie Griffin of Claxton, President of the Woman's Auxiliary to the Medical Association of Georgia.

A noted medical teacher and internal medicine specialist addressed the WARE COUNTY MEDICAL SOCIETY September 2, 1965, on the subject, "Sarcoidosis—A Regional Disease." Max Michael, Jr., M.D. of Jacksonville, Florida, is considered one of the foremost world authorities on the disease which closely resembles tuberculosis but is not caused by the TB bacterium. Dr. Michael has lectured on Sarcoidosis throughout the U.S. and in foreign countries.

## SPECIALTY SOCIETIES

The GEORGIA STATE OB-GYN SOCIETY held a meeting November 15, 1965, at Grady Memorial Hospital Auditorium, Atlanta, in conjunction with a postgraduate course sponsored by the Emory University School of Medicine GYN-OB Department. Guest speaker for the OB-GYN SOCIETY meeting was Dennis Cavanagh, M.D., Professor of OB-GYN of the University of Miami, Florida. Dr. Cavanagh spoke on "Prematurity and the Obstetrician." The postgraduate conference sponsored by Emory concerned "Gynecologic Cancer."

The GEORGIA ORTHOPEDIC SOCIETY met September 23-25, 1965, at The Cloisters, Sea Island, Georgia. Invited Guest Speaker was Fred Thompson, M.D. of New York City who spoke on "Management of the Metropolitan Tibia," and also presented a "medley" of unusual orthopedic cases. Newly elected officers of



the Society include William Bondurant, M.D., Atlanta, President; James Harkess, M.D., Augusta, Vice-President; and Robert Wells, M.D., Atlanta, Secretary-Treasurer. The next annual meeting of the Society will be in October of 1966 at the same location.

The GEORGIA PEDIATRIC SOCIETY held its 33rd Annual Scientific Meeting in Atlanta, October 14, 1965, at the Progressive Club. The meeting brought together pediatricians from Georgia, North and South Carolina, Alabama, Florida and Tennessee.

Among the Speakers addressing the Society were: Marvin Cornblath, M.D., Professor of Pediatrics, University of Illinois College of Medicine, Chicago, Illinois. His subjects were, "Neonatal Symptomatic Hypoglycemia and Nonhemolytic Hyperbilirubinemia in the Premature Infant."

William E. Laupus, M.D., Chairman, Department of Pediatrics, Medical College of Virginia, Richmond, Virginia. His subjects were, "Newborn Physiology Revisited and Changing Concepts of the Care of Premature Infants."

Lewis M. Fraad, M.D., Professor of Child Health and Acting Chairman, Department of Pediatrics, Albert Einstein College of Medicine, Bronx, New York. His subjects concerned, "Abdominal Pain in Childhood" and "Is Mental Health Supervision Consistent With a Busy Pediatric Practice?"

The all-day meeting was followed in the evening by a dinner for the wives and members of the Society. Officers are: Martin H. Smith, M.D., Gainesville, President; Oscar S. Spivey, M.D., Macon, President-Elect; Dorothy Brinsfield, M.D., Atlanta, Vice-President; Marvin L. Davis, M.D., Atlanta, Secretary-Treasurer; Joseph Yampolsky, M.D., Atlanta, Chairman, Local Arrangements Committee.

The fall sectional meeting of the AMERICAN COLLEGE OF PHYSICIANS was held in Miami, October 7-10 with seventeen members of the Medical Association of Georgia in attendance. The next annual session of the College is in New York City April 18-22, 1966, and all members and guests are welcome to attend.

**PERSONALS**

**Fifth District**

A native of Eatonton, Georgia, JULIAN A. JARMAN, has joined the Atlanta Veterans Administration as Chief of Staff. Since August, 1962, Dr. Jarman has served as Medical Advisor for the Fulton-DeKalb Hospital Authority.

Appointment of Major RAYMOND R. BARNETT, U.S. Army, retired, as Assistant Director of the Georgia Hospital Association has recently been announced by Mr. Glenn M. Hogan, Executive Director.

**"THE MEDICAL UNITS 'PLANNING GUIDE'" AND "THE BUSINESS SIDE OF MEDICAL PRACTICE" ARE AGAIN AVAILABLE TO GEORGIA DOCTORS**

For the third consecutive year, the Medical Association of Georgia is offering to the doctors of Georgia the American Medical Association-Sears, Roebuck Foundation, Inc. booklets entitled, "The Business Side of Medical Practice," and "The Medical Units 'Planning Guide.'" The material is free of charge and either or both may be obtained by writing to the *MAG Head-*

JOSEPH L. IZENSTARK, Atlanta, has been appointed consultant to the United States Army in Radiology and Nuclear Medicine.

H. SCOTT PATTERSON, Chamblee, has been named medical director of Atlanta-based American Agency Life Insurance Companies.

A. H. LETTON, Atlanta, was the guest speaker for the Cedartown and Rockmart Units of the American Cancer Society at their annual meeting in Cedartown, August 23, 1965.

Professor and Chairman of the Department of Obstetrics and Gynecology at Emory University School of Medicine, JOHN D. THOMPSON, Atlanta, has received an unrestricted grant for medical research from Wyeth Laboratories, Philadelphia.

JOHN T. MAULDIN, Medical Director of the Georgia Department of Family and Children Services' program of Medical Assistance to the Aged, was elected to a three-year term on the Executive Committee of the American Association of Public Welfare Medical Directors at its first annual meeting in New York City recently.

ELEANOR B. PETRIE, Atlanta, Assistant Health Director of the DeKalb County Health Department for the past ten years, has accepted the position of Medical Director, Nutrition Section, Georgia Department of Public Health.

SIDNEY OLANSKY, Atlanta, traveled to Detroit to participate in the 100th Annual Meeting of the Michigan State Medical Society September 21-24, 1965. On the 22nd he conducted a Symposium on Syphilis, 1965, and addressed the Michigan State Dermatologists on, "The Newer Immunologic Aspects of Syphilis." On the 23rd he was guest professor at the Henry Ford Hospital at Detroit.

JAMES V. ROGERS and R. WALDO POWELL, Atlanta, presented a paper, "Comparative Mammography Study," to the American Roentgen Ray Society convention held in Washington, D.C., September 28-October 1, 1965.

**Eighth District**

J. L. WALKER of Nahunta closed his office August 28, 1965, to accept a post as Medical Director of a corporation in Newton, Iowa.

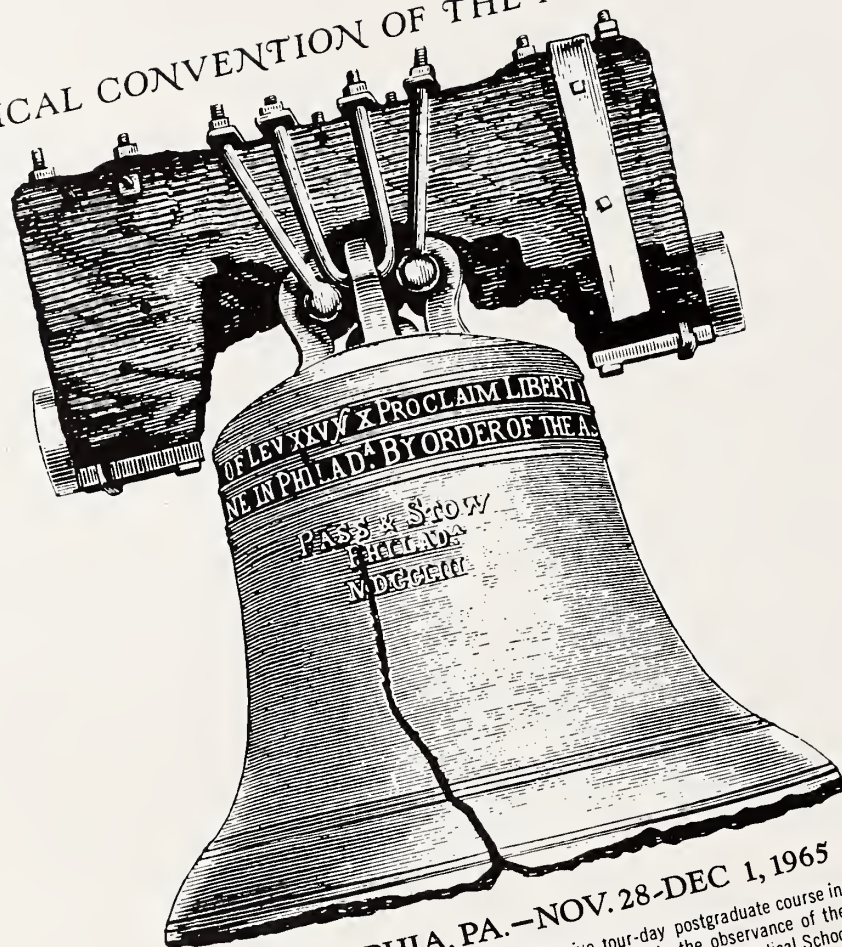
**Tenth District**

Guest speaker for the September meeting of the Augusta Rotary Club was LOUIS R. BATTEY of Augusta, who heads the Georgia Heart Association. Dr. Battey discussed heart attacks.

*quarters Office, 938 Peachtree St., N.E., Atlanta, Ga. 30309.*

Each booklet, constructed of heavy vellum stock, measures approximately 12" x 9" and contains charts, graphs, illustrations, floor plans, etc. Both are made for easy handling and make a nice addition to a doctor's office library.

# 19th CLINICAL CONVENTION OF THE AMA



## PHILADELPHIA, PA. — NOV. 28-DEC 1, 1965

Plan to attend the world's most comprehensive four-day postgraduate course in recent developments in medical science, and participate in the observance of the founding of the first medical college established in this country—the Medical School of the University of Pennsylvania.

This postgraduate refresher course, conducted by the nation's outstanding medical authorities, will be presented for you in historical Philadelphia. Philadelphia has many luxurious hotels and colorful restaurants. Mail the enclosed registration and room reservations coupons now!

**TWO POSTGRADUATE COURSES:** Gynecology and Obstetrics; and Cardiovascular Therapeutics (each to be presented in 3 half-day sessions) **BREAKFAST ROUND-TABLE DISCUSSIONS:** Gynecologic Difficulties in the Adolescent • Early Management of Traffic Accident Patients • Common but Worrisome Pediatric Problems • The Nature of Chronic Bronchitis and Pulmonary Emphysema • Prevention of Long Term Illness: A Practical Approach • Clinical Uses of Electroencephalography

**SCIENTIFIC SESSIONS:** Ulcerative Colitis • Pediatrics • Chemotherapy of Cancer • Preventive Surgery in Cancer • Bacterial Infections • Ultraviolet Irradiation in Medicine • Genetics • Current Status of Drug Therapy in Rheumatology • Psychiatry • Urology • Gastrointestinal Surgery • Cardiovascular Surgery • Current Concepts of Shock • Computers in Medicine • Pain in the Back • Orthopedics • Common Otology Problems • Eye Problems and the Non-Ophthalmologist • CLOSED CIRCUIT COLOR TELEVISION • MOTION PICTURE PREMIERES • Hundreds of SCIENTIFIC AND INDUSTRIAL EXHIBITS

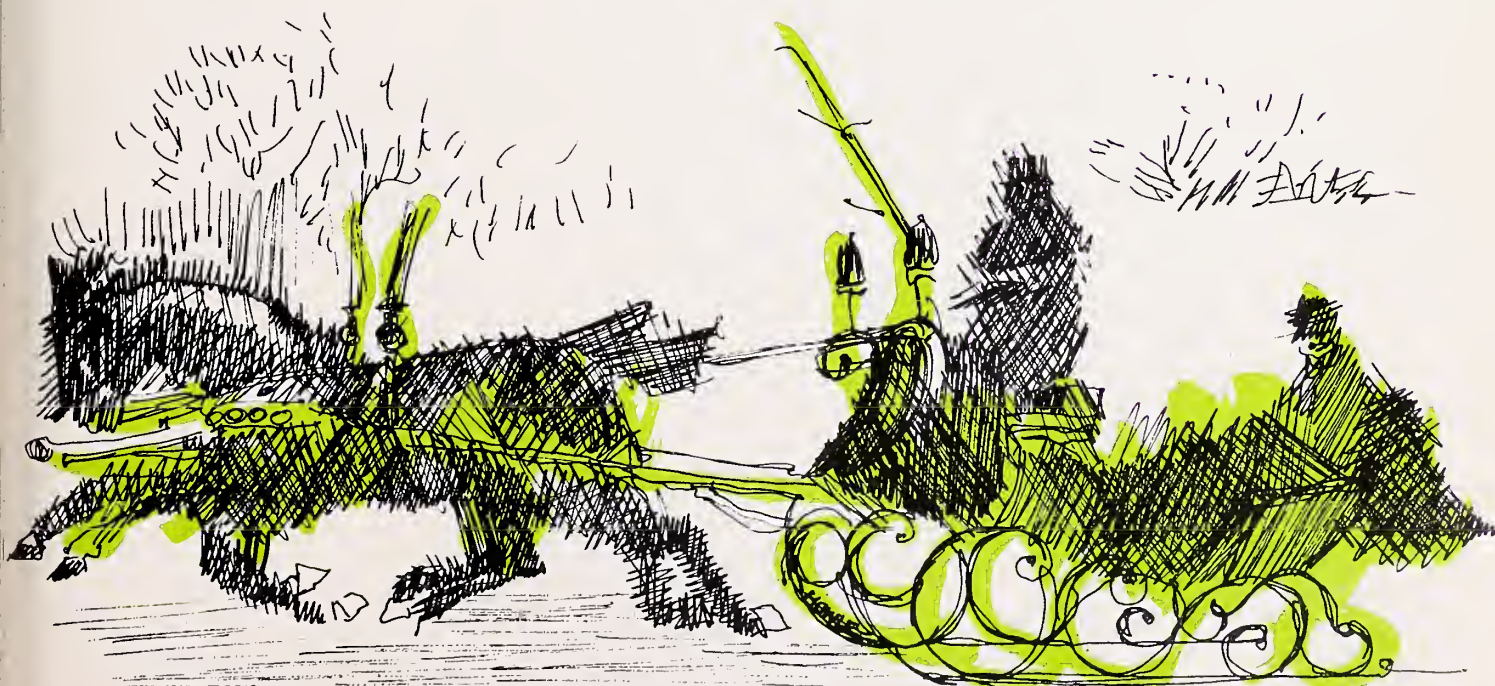
The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA October 25



**JOURNAL**  
OF THE **MEDICAL**  
ASSOCIATION

DECEMBER/1965  
*Georgia*

U.C. MEDICAL CENTER LIBRARY  
DEC 23 1965  
San Francisco 22





**the difference between cough and relief**

## **Benylin® Expectorant**

Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5 per cent alcohol.

**for relief of coughs due to colds or allergy**

**PRECAUTIONS:** Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers, if used with BENYLIN EXPECTORANT, should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT. **PACKAGING:** Bottles of 4 oz., 16 oz., and 1 gallon.

72165

**PARKE-DAVIS**

PARKE, DAVIS & COMPANY, Detroit, Michigan 48232



**JOURNAL  
OF THE MEDICAL  
ASSOCIATION**

*Georgia*

**EDITOR**

Edgar Woody, Jr., M.D.

**MANAGING EDITOR**

Miss Merrilie M. Davis

**STAFF**

Thelma V. Franklin, *Business*

**CONTRIBUTING EDITORS**

Herbert S. Alden, M.D.; Preston D. Ellington, M.D.; Thomas Findley, M.D.; J. Willis Hurst, M.D.; Charles S. Jones, M.D.; Arthur M. Knight, Jr., M.D.; Arthur J. Merrill, M.D.; Lester Rumble, Jr., M.D.; Peter L. Scardino, M.D.; Patrick C. Shea, Jr., M.D.; Robert H. Vaughan, M.D.

**PUBLICATIONS COMMITTEE**

George H. Alexander, M.D.; Walter E. Brown, M.D.; J. G. McDaniel, M.D.; Henry S. Jennings, M.D.; Charles R. Andrews, Jr., M.D.; John T. Mauldin, M.D.; John S. Atwater, M.D.; F. G. Eldridge, M.D.

**THE ASSOCIATION**

George H. Alexander, M.D., *Pres.*; Walter E. Brown, M.D., *Pres.-Elect*; J. G. McDaniel, M.D., *Past Pres.*; Charles R. Andrews, Jr., M.D., *Chm. of Council*; John T. Mauldin, M.D., *Sec.*; John S. Atwater, M.D., *Treas.*; J. Frank Walker, M.D., *Speaker*; Mr. Milton D. Krueger, *Exec. Sec.*; Mr. James M. Moffett, *Asst. Exec. Sec.*; Mrs. Catherine Wooten, *Asst. Exec. Sec.*

THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and copyrighted, 1965, by the Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, Georgia 30309. Published monthly under the direction of the Council of the Association. Subscription rate: \$7 per year; \$1 per single copy. Second-class postage paid at Fulton, Missouri.

**Contents**

**Scientific Articles**

ROENTGENOLOGIC OBSERVATIONS CONCERNING PULMONARY COMPLICATIONS OF ACHALASIA	
Colin B. Holman, M.D.	391
CLINICAL USES OF AMNIOCENTESIS: A REVIEW	
Eduardo Talledo, M.D. and F. P. Zuspan, M.D.	395
THE AIRWAY IN HEAD AND NECK SURGERY	
Daniel B. Sullivan, M.D.	399
CONGENITAL ANOMALIES OF THE UPPER EXTREMITY	
Frank H. Stelling, M.D.	402

**Editorials**

A PHYSICIAN'S CHRISTMAS STORY	410
MEDICARE RULES SOON TO BE DETERMINED	410

**Features**

The President's Letter	412
Cancer Page	417
Heart Page	419
Mental Health Page	420

**The Association**

Deaths	422
Personals	422
Calendar	409
Advertising Index	48A

**Cover**

Design by Bobbie Howell, Atlanta



## Anatomy of Low Back Pain #1



**the sedentary life  
is often the seat of  
low back pain**

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stress set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

*The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ to relieve pain ☐ to relax muscles ☐ to restore mobility.*

**Indications:** 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

**Contraindications:** Allergic or idiosyncratic reactions to carisoprodol.

**Precautions:** 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

**Side Effects:** The only side effect reported with frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Occasionally observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leucopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with hypotension, shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

**Dosage:** Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

**Supplied:** Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

*Before prescribing, consult package circular.*

**for the relief  
of low back  
sprains and strains**

**SOMA**  
(CARISOPRODOLOL)



Wallace Laboratories, Cranbury, NJ 08510



# ROENTGENOLOGIC OBSERVATIONS CONCERNING PULMONARY COMPLICATIONS OF ACHALASIA

Colin B. Holman, M.D., *Rochester, Minnesota*

## ■ Pulmonary fibrosis is common in these patients.

IN 1953, Andersen, Olsen and I reported on 63 cases of pulmonary complications found among 601 patients with cardiospasm who had been observed and treated at the Mayo Clinic between 1935 and 1946. At that time, because of the approximately 10% incidence of significant respiratory disease among patients with cardiospasm, it was thought that the pulmonary complications of cardiospasm required special attention. Inasmuch as more than ten years have elapsed since that study, it was thought advisable to re-investigate the subject and to determine, if possible, whether or not a significant number of such complications continue to occur in these patients and whether or not any new or different complications have been noted. Because it is possible to treat achalasia, with considerable success, by means of dilatation of the stricture or by various operative procedures, a new review of these complications may produce information helpful in the management of such patients.

### Review of the Literature

During the past 12 years, several papers have been published dealing with this subject from various points of view.<sup>2-6, 8</sup> In a review in 1964, Barrett reported several observations regarding the association of cardiospasm and various pulmonary diseases. Essentially the same mechanism was proposed for all of these complications, and it can be regarded as "spill over." Barrett thought that spill over occurred in association with cardiospasm because of obstruction at the lower end of the esophagus with retention of food and fluid in a long column within the organ;

and he observed that, in treatment, it was necessary to prevent the stagnation of food and fluid within the gullet. It also was stated that oily materials frequently float on the top of the column of fluid and, therefore, are most likely to be aspirated into the bronchial system. The type and extent of the disease were thought to depend considerably on the volume of material aspirated. Small volumes can reach the periphery of the lung and result in peripheral bronchial embolism and pulmonary abscesses; larger volumes are likely to cause a more diffuse pneumonitis. The position of the patient, the volume of the aspirated material, the volume of the fluid in the esophagus, and the nature of the material were all proposed as factors of considerable importance in determining the nature of the lesion. The lesions were reported to be less common in the bases of the lungs, although this was not noted in the present study.

Barrett also called attention to the adverse effects of the aspirated material due to osmotic changes, irritation of the mucosa, and eventual development of pulmonary hypertension resulting from the pulmonary complications. The correct diagnosis is usually not difficult since most patients have a huge esophagus, and evidence of the condition can be seen on the thoracic roentgenogram. In Barrett's series, of 48 patients with achalasia, eight had pulmonary lesions.

Another factor, which various authors have commented on, is the possible presence of saprophytic mycobacteria in the fluid within the esophagus. Identification of these types of microorganisms is important because, unless the existence of these saprophytes is proved, one might erroneously believe that

Presented at the 111th Annual Session of the Medical Association of Georgia, May 2, 1965, Augusta, Georgia.

the recovery of mycobacteria indicated pulmonary tuberculosis and that the lesions in the lungs were due to tuberculosis. Gibson suggested that the pathogenesis of infection due to these types of organisms probably depends more on the reaction of the host and on the environment to which the organisms are exposed than it does on the organism itself and that the synergistic action of fat with mycobacteria is a key to these unusual infections. He reported on a patient (in Glasgow, Scotland) with cardiospasm who died with pulmonary infection associated with a lipoidal and suppurative bronchial pneumonia due to a strain of acid-fast bacilli of an unusual species of *Mycobacterium*.

Development of Cor Pulmonale

Steinberg and Finby called attention to the possibility of the development of cor pulmonale due to the chronic pulmonary fibrosis resulting from lipid pneumonia secondary to cardiospasm. By 1954, Wilmore had collected, from the literature and from his own experience, a total of 137 cases of pulmonary complications resulting from cardiospasm. He reported that in his own series there was also a 10% incidence of this complication with achalasia. Although the present report is concerned only with the pulmonary complications of achalasia, many other complications are mentioned in the literature. These include rupture, carcinoma and peptic ulcer of the esophagus, diaphragmatic hernia, pressure from a mega-esophagus on an adjacent organ, hilar node calcification, mega-esophagus with enlarged stomach, dysphagia, esophagitis, and mediastinitis.

The clinical records of all patients at the Mayo Clinic in whom the diagnosis of cardiospasm or of suspected cardiospasm was made between the years 1946 and 1964 were studied. From the records, the patients were divided into three groups: (1) those in whom a diagnosis of cardiospasm had been made primarily by roentgenologic means; (2) those in whom a diagnosis had been made by esophagoscopy or by surgical exploration; and (3) those in whom a

diagnosis of cardiospasm was made by tests of esophageal motility.

Some patients could have been included in more than one group, but separate diagnostic groups were maintained in an attempt to determine whether or not pulmonary complications of cardiospasm could arise in a patient in whom no convincing evidence of the disease was apparent by roentgenologic examination. There were 934 patients in all, 571 in the roentgenologic group, 162 in the esophagoscopic and surgical group, and 201 in the esophageal motility group. Of these, 62 patients (6.6%) had evidence of pulmonary complications which probably resulted from significant cardiospasm (Table).

From a roentgenologic standpoint, four stages of cardiospasm were established in order to relate the degree of cardiospasm to the incidence of pulmonary complication. *Stage 1* consisted of slight dilatation—little or no appreciable increase in the diameter of the esophagus. In these cases, the roentgenologic appearance of the esophagogastric juncture is more narrow than usual and, although the first swallow of the thin mixture of barium sulfate may pass through the orifice, there is retention of fluid in the lower 5 to 10 cm of the lumen for a short time. Ordinarily, there is no retained food or fluid in the esophagus at the time of examination. Following the ingestion of the opaque mixture, there may be some increase in the muscular activity, principally as a short succession of secondary peristaltic waves which may milk the barium upward in the esophagus unless the cardiac sphincter opens. At this time it may be difficult to ascertain the nature of the obstruction. It is in these cases that the motility studies are most helpful.

Stage Two

In *Stage 2* the esophageal lumen, except for the diaphragmatic portion, is wider than normal. Retained food and fluid may be present in the lower portion of the esophagus and the opaque mixture, being more dense, shifts downward to the lowest part of the esophagus and is retained in this location. The luminal outline appears to be conical and narrowed for a short distance with a beak-like extension directed into the spastic segment. Some increase in muscular activity may be evident, which suggests ineffectual peristalsis. Seldom, however, does enough barium pass through the narrowed segment at this time to permit adequate examination of the stomach.

*Stage 3* is diffuse dilatation of the organ, and the presence of cardiospasm is readily suggested on fluoroscopic examination. There is usually no gas bubble in the fundus of the stomach. At the onset of this stage of cardiospasm, elongation of the esophagus may not be appreciable although the organ is considerably larger in caliber than usual. Peristalsis is

PULMONARY COMPLICATIONS OF CARDIOSPASM

Complications	Number of Cases	
	First series (1935-1946)	Present series (1946-1964)
Total cases of cardiospasm	601	934
Aspiration pneumonitis	46	50
Unilateral	26	37
Bilateral	20	13
Pulmonary fibrosis	3	6
Bronchiectasis	5	3
Pulmonary abscess	1	4
Emphysema	2	2
Coexistent neoplasm	0	5
Pulmonary nodules	0	4



not demonstrable but, on rare occasions, multiple, small, segmental contractions may be seen, which presumably represent the so-called tertiary contractions described by Templeton.

*Stage 4* is characterized by marked enlargement of the esophagus. The advanced cardiospasm of long standing with marked dilatation, elongation, and angularity of the esophagus is usually recognized. This is the decompensated form of cardiospasm. The esophagus above the stenotic portion may be tremendously dilated, and occasionally it occupies almost the entire right half of the thorax. Usually, the esophagus is a dilated and tortuous, patulous pouch, filled with food and fluid. Frequently, its lower third assumes an "S" shape and this has been referred to as the sigmoid esophagus of cardiospasm. Frequently, too, the column of food and fluid, when limited superiorly by its air-fluid interface, can be detected fluoroscopically or on a roentgenogram of the thorax made with the patient in the upright position. Ingested opaque fluid can be seen fluoroscopically to sink through the retained contents of the esophagus and outline the terminal portion of the organ. There is no evidence of muscular activity or peristalsis.

### Aspiration Pneumonitis

Fifty of the 62 patients who had pulmonary complications had pneumonitis which presumably resulted from aspiration of esophageal contents. Roentgenologic examination showed that in 37 patients the pneumonitis was unilateral and in 13 it was bilateral. Among those with unilateral involvement, the right lung was involved in 21 and the left lung was involved in 16. In three patients, more than one region of a lung was affected. In contrast, in the previous study there were 21 patients with involvement on the right side and only five with involvement on the left side. In the present study it was obvious that, in the right lung, the middle third was affected somewhat more often than was either the upper or lower portion. On the left side there was no particular difference between the involvement of the middle and lower lung fields. In the 13 patients with bilateral involvement, both lungs were involved either partially or extensively. No portion of the pulmonary fields escaped involvement but infection predominated in the middle third.

An attempt was made to relate the roentgenologic stage of achalasia with the occurrence of these pulmonary lesions. Of the 62 cases it was possible to judge the degree of roentgenographic change in 47: 34 patients were regarded as having a stage three or stage four lesion, six had a stage two lesion, three had a stage one lesion, and four had an esophagus of normal appearance at roentgenographic and fluoroscopic examination. Aspiration pneumonitis was usu-

ally associated with stage three and stage four cardiospasm. However, these lesions were present in three cases in which esophageal achalasia appeared to be stage two. In the four cases in which the esophagus appeared to be normal on roentgenologic examination, the diagnosis of achalasia was made by esophageal motility studies; aspiration pneumonitis was found in these four cases.

### Other Complications

As noted in our previous study, the pneumonitis associated with cardiospasm may vary from an acute episode followed by rapid recovery, both symptomatically and roentgenologically, to an insidious, chronic, indurative process that persists indefinitely. There is no reason to change our previous opinion that the condition is more likely to persist when the amount of lipid in the esophageal contents is high, such as occurs in those patients who ingest mineral oil, milk, or other dairy products before going to bed. Fibrosis is probably the most frequent end result of aspiration pneumonitis. However, other complications can occur, such as the development of a pulmonary abscess.

In some instances it is difficult to determine accurately from a roentgenogram of the thorax whether a lesion represents active pneumonitis or fibrosis. Minimal fibrotic lesions in lungs were not included in this study because it is not possible to be certain that the fibrosis might not have occurred long before the esophageal problem developed. The separation of aspiration pneumonitis from fibrosis is probably not justified because the fibrosis may be an end result of the pneumonitis. However, since the fibrosis in these cases was diffuse and was associated with bleb formation, it is possible that factors other than cardiospasm might have produced it. In other words, there is no reason to believe that a patient with fibrosis associated with emphysema or some other cause might not also have cardiospasm. There were six patients with diffuse pulmonary fibrosis with bleb formation, in contrast to only three such patients in the earlier series.

### Bronchiectasis

There were three patients for whom the diagnosis of bronchiectasis was suggested but in none of these was it proved by bronchography. The clinical histories of these patients were quite consistent with a diagnosis of bronchiectasis, and it is likely that the aspiration of the esophageal contents was probably directly related to the development of bronchiectasis.

There were four instances in which a definite pulmonary abscess could be diagnosed from the roentgenogram of the thorax. One of these patients had been included in the previously reported study. There



were no cases in which a diagnosis of probable tuberculosis was made. It is always important that each pulmonary lesion be investigated thoroughly for the presence of *Mycobacterium tuberculosis* and that the associated cardiospasm be treated adequately to allow the patient to take full nourishment. It is very important, however, to recognize that saprophytic acid-fast bacilli also can be recovered from these patients (this may cause some confusion until the organisms are identified). For example, acid-fast organisms were found in the sputum and gastric washings of a patient in our first series but these organisms produced no disease when injected into a guinea pig. This complication was thoroughly discussed by Gibson.

### Emphysema

Although two patients in this series (and two in the previous series) showed what might be regarded as evidence of emphysema on thoracic roentgenograms, it is difficult to assess objectively a possible role of aspiration in the development of asthma or emphysema. It seems reasonable to assume that an associated tracheobronchitis caused by repeated aspiration of small amounts of esophageal contents with bronchospasm could exist and this might be sufficient to cause wheezing. However, there is no direct evidence that the asthma was caused by cardiospasm. The small number of cases would make this statistically insignificant in any event.

### Neoplasm

In the previous report, no reference was made to the possible coexistence of neoplasm with achalasia. It is interesting to note that, of the 62 patients in whom an abnormality in the lung fields was demonstrated on a thoracic roentgenogram, five patients had some form of neoplasm involving the pulmonary structures. In two patients carcinoma of the lung developed, apparently during the time the patients had cardiospasm. Also, cardiospasm and myeloma coexisted in one patient, carcinoma of the esophagus developed in one patient, and one patient had carcinoma of the breast with metastasis to the lungs. Another patient had Hodgkin's disease with involvement of the lungs.

There were four patients in whom indeterminate pulmonary nodules were noted in the lung fields; in one of these, the nodules very much resembled those resulting from metastasis but there was no pathologic diagnosis for confirmation. The importance of these observations is that neoplasm may coexist with cardiospasm but possibly not be related to it—every

lesion which presents as a pulmonary infiltration in the presence of cardiospasm is not aspiration pneumonitis and, therefore, measures for definitive diagnosis are indicated.

### Summary

From 1946 to 1964, 934 patients thought to have cardiospasm were seen at the Mayo Clinic and 62 (6.6%) of them had pulmonary complications. The roentgenologic appearance of the lesion follows a relatively characteristic pattern. The most frequent location seems to be the midportion of the right lung although it may be in any portion of either lung. The pneumonitis is frequently bilateral and may simulate tuberculosis, silicosis, metastatic carcinoma, or primary neoplasm. The lesions usually accompany cardiospasm after it has developed into the advanced stage so that the evidence of achalasia is frequently apparent in the thoracic roentgenogram which also shows the pulmonary involvement. These features of cardiospasm include widening of the mediastinum to the right, an air-fluid interface in the esophagus, and a lack of the usual air bubble in the stomach.

Pulmonary fibrosis is common in these patients and probably represents the end result of aspiration pneumonitis. Roentgenographic changes suggestive of bronchiectasis occurred in two patients, and there were four in whom a pulmonary abscess was well demonstrated. When pulmonary infiltrations are detected, it is well to consider the possibility of esophageal obstruction resulting from cardiospasm, inasmuch as corrective treatment of achalasia is available. A relatively high incidence of pulmonary complications provides an additional reason for prompt institution of treatment after cardiospasm is recognized.

### REFERENCES

1. Andersen, H. A.; Holman, C. B., and Olsen, A. M.: Pulmonary Complications of Cardiospasm; *J.A.M.A.* 151: 608, 1953.
2. Barrett, N. R.: Association of Esophageal and Pulmonary Diseases; *Postgrad. Med.* 36:470, 1964.
3. Gibson, J. B.: Infection of the Lungs by "Saprophytic" *Mycobacteria* in Achalasia of the Cardia, With Report of a Fatal Case Showing Lipoid Pneumonia Due to Milk; *J. Path. & Bact.* 65:239, 1953.
4. Laff, H. I.: Cardiospasm Associated With Pneumonitis, Bronchial Granuloma and Broncholithiasis; *Ann. Otol., Rhin. & Laryng.* 62:144, 1953.
5. Schrijver, H.: Recidiverende pneumonien door cardiospasmus; *Belg. tijdschr. geneesk.* 12:132, 1956.
6. Steinberg, Israel, and Finby, Nathaniel: Lipoid (Mineral Oil) Pneumonia and Cor Pulmonale Due to Cardiospasm: Report of a Case; *Am. J. Roentgenol.* 76:108, 1956.
7. Templeton, F. E.: Movements of the Esophagus in the Presence of Cardiospasm and Other Esophageal Diseases: A Roentgenologic Study of Muscular Action; *Gastroenterology* 10:96, 1948.
8. Wilmore, R. C.: Pulmonary Changes Secondary to Cardiospasm; *J. Indiana M. A.* 47:25, 1954.

Section of Roentgenology  
Mayo Clinic and Mayo Foundation



# CLINICAL USES OF AMNIOCENTESIS

Eduardo Talledo, M.D. and  
F. P. Zuspan, M.D., *Augusta*

- Indications and techniques for carrying out this procedure are discussed.

THE CLINICAL USEFULNESS of amniocentesis (the puncture of the amniotic sac through the abdominal route) has been broadened in the last few years and opened new fields for clinical obstetrics. The older literature refers to amniocentesis only as a treatment for excessive degrees of polyhydramnios. Alvarez and Caldeyro-Barcia<sup>1</sup> popularized transabdominal amniocentesis in their study of uterine contractility. Since amniocentesis is being used more now and will continue to be used, a brief critical review of the technique is necessary.

## Technique

Premedication as a general rule is not necessary. The procedure is explained carefully to the patient, and she is reassured that it is safe for both her and the baby. The bladder should be emptied and the fetal position determined by palpation. The skin of the abdomen is thoroughly cleaned with a detergent solution or topical antiseptic. The site selected for the amniocentesis is usually below the umbilicus and in the midline. This location avoids most fundal implanted placentas and also is where the uterus is closest to the abdominal wall. After draping the patient with sterile towels, the skin, subcutaneous tissue, fascia and the peritoneum are infiltrated with a local anesthetic. A 17 or 18 gauge three-and-a-half inches long thin-wall needle attached to a syringe filled with saline is introduced. Piercing of the peritoneum produces minor discomfort indicating that the needle is in the peritoneal cavity and can be further tested by the ease with which fluid is injected. The uterine wall is next encountered; it is recognized because it offers resistance to the introduction of fluid. Next, a sudden give is felt as the needle enters the amniotic sac; amniotic fluid can then be sampled.

It is important to avoid traumatic taps. If the placenta is located anteriorly, blood will be aspirated instead of amniotic fluid. The needle should be withdrawn and a puncture done in another area. A potential danger exists if the placenta is perforated and a large chorionic vessel is lacerated. Such a laceration could produce exsanguination of the fetus. If the

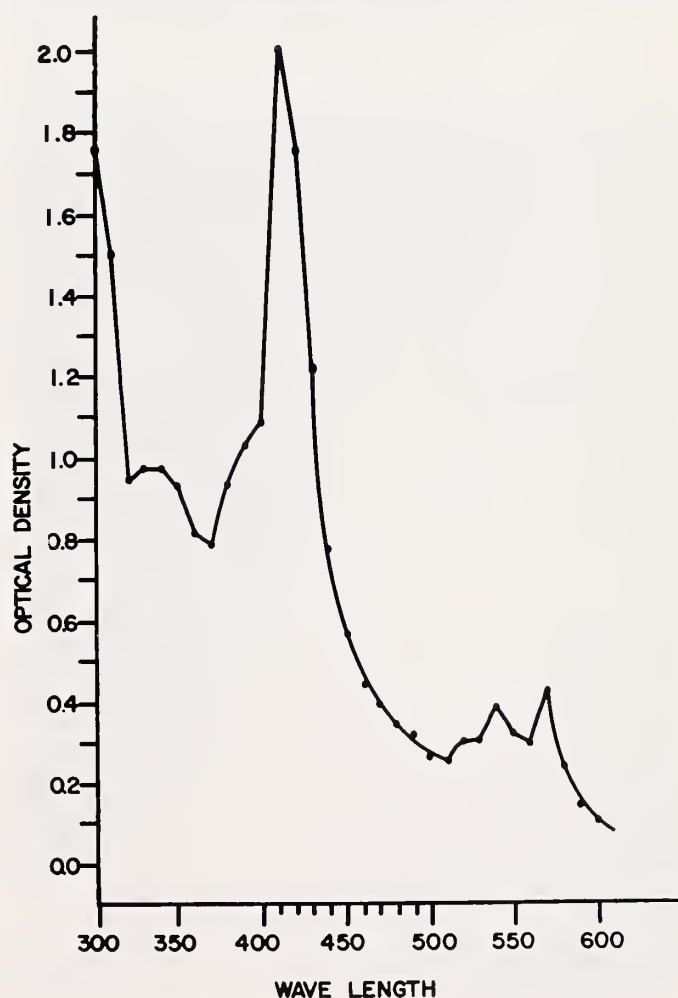


FIGURE 1

The spectrum of a "bloody tap" showing a high "peak" at 410 millimicrons. The slope of the normal curve is reassumed at 450 mμ.

\*Aided in part by Public Health Service Research Grants HE-09289-01 from the National Heart Institute and Grant HD-00531-03 from the National Institute of Child Health and Human Development.

technique is observed carefully such an event is extremely unlikely. Over a four year period and hundreds of taps, this complication has never been encountered.

Indications

Amniocentesis is useful for the following:

- 1. Therapeutic
- 2. Diagnostic
- 3. Research Studies

1. Therapeutic

Polyhydramnios: Amniocentesis is helpful to decrease the size of the uterus if embarrassment of circulatory or respiratory systems is due to overdistension of the uterus by excessive amniotic fluid. Lesser degrees of uterine distention, as seen in multiple pregnancy, might require amniocentesis to facilitate initiation of labor by making uterine work more effective. There is an inverse relationship between uterine volume and effectiveness of uterine contractions.<sup>2</sup>

Induction of Labor

Csapo,<sup>3</sup> following earlier experiments by Corner and Allen,<sup>4</sup> and Reynolds,<sup>5</sup> developed the concept of "progesterone block" which would be the normal mechanism by which pregnancy is preserved. At term, due to unknown factors, this block is removed and labor ensues. Applying this concept to cases of fetal death in utero with retention of the products

of conception (missed abortion and fetal demise) hypertonic solutions (saline 20%, glucose 50%) injected by amniocentesis were used to remove the "progesterone block" and induce labor. Though the mechanism remains unclear, it is effective. After a latent period of several hours, labor begins and progresses normally. It is important to emphasize that injections of hypertonic solutions should not be given unless the needle is in the amniotic cavity as determined by free flow of amniotic fluid, otherwise complications (e.g. peritoneal irritation) may occur.

2. Diagnostic

Diagnostic amniocentesis came into prominence by the reports of Liley<sup>6</sup> in using amniocentesis in patients with Rh incompatibility for early detection of compromised infants. His decision was based on, "A need for a reliable assessment of the condition of the baby in utero as well as, a warning of potential intra-uterine death, in order that the best compromise between maturity and anemia can be achieved." Analysis of the amniotic fluid has proven more useful than anti-Rh-antibody titres. The analysis of the amniotic fluid by spectrophotometry is not difficult; however, the handling of the specimen may be critical if certain precautions are not observed. The amniotic liquor should be protected from light by a dark sterile bottle. The specimen is refrigerated if analysis of the liquor is to be done at a later date. The optical densities of the liquor when plotted at different wave lengths give a smooth down slope curve. A small "peak" is fairly constant at 410 millimicrons which is believed due to blood contaminant. Blood or "bloody specimens" studied by spectrophotometry

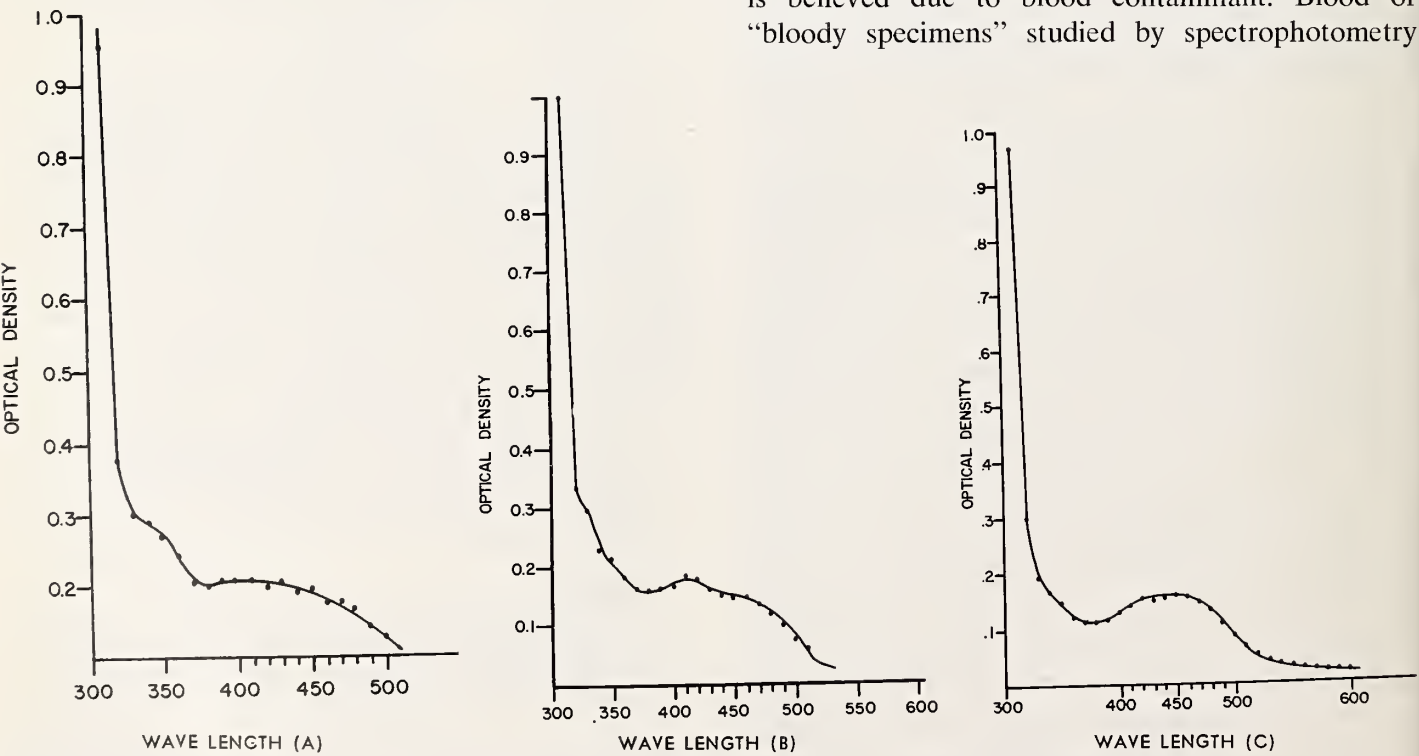


FIGURE 2

It shows the spectrophotometric study of the amniotic fluid in a patient with Rh sensitization at (A) 31 weeks, (B) 33 weeks and (C) 35 weeks. Notice the worsening of the "hump" between 400-500 millimicrons.



produce a "peak" at 410 millimicrons (Figure 1). In cases of hemolytic disease a "hump" and not a "peak" is found between 400-500 millimicrons (Figure 2). The height of the "hump" is usually proportional to the severity of the disease. If the liquor is studied serially (every 10-14 days) in a sensitized patient, a progressive increase in the area of "the hump" indicates a poorer prognosis. Amniocentesis is first done at 28-30 weeks and then every two weeks. It is only recommended in proven Rh sensitized patients as it carries a potential immunizing hazard.<sup>7-8</sup>

### Localization of Placenta

An opaque medium (hypaque, 75%) is introduced into the amniotic cavity. Soft parts i.e. fetus and placenta—are seen satisfactorily on x-ray at 45-60 minutes (Figure 3); thereafter, the medium is reabsorbed by the mother and swallowed by the fetus. Films taken after one hour will reveal the contrast medium in the fetal gastrointestinal tract (Figure 4). Consequently, it may be helpful if the presence of congenital abnormalities of the digestive tract or fetal death are suspected. Amniography is more accurate to localize the placenta than soft tissue technique. In cases of missed abortions and fetal death in utero labor usually follows. Premature labor in viable pregnancies has not been encountered.

### 3. Research Studies

Intrauterine transfusion was a corollary of the above studies. As a therapeutic procedure it should be considered a research technique for the present time. Fetuses who are detected to have a severe hemolytic anemia by study of the amniotic fluid (30 to 32 weeks) cannot be allowed to continue their intrauterine existence because of increased incidence of stillbirth yet, if delivered, the majority will die due to a prohibiting degree of prematurity summing to the hemolytic process. Intrauterine transfusion may be the only salvation for those sensitized fetuses.<sup>9</sup> A plastic tubing is introduced in the fetal peritoneal cavity through an amniocentesis needle after localization with radiopaque material. Packed red cells (between 50 and 100 cc's in volume) are given. The cells are reabsorbed by the fetus ameliorating the severity of the anemia. The procedure can be repeated in one or two weeks. It should be done in the hospital by a combined obstetric-pediatric team trained in both clinical and technical aspects of hemolytic disease.

Through amniocentesis the behaviour of the human uterus under normal and pathological conditions has been studied. Moreover, the uterine response to drugs has been reevaluated and safer methods for



FIGURE 3

Antero-posterior view showing the placenta as a filling defect.

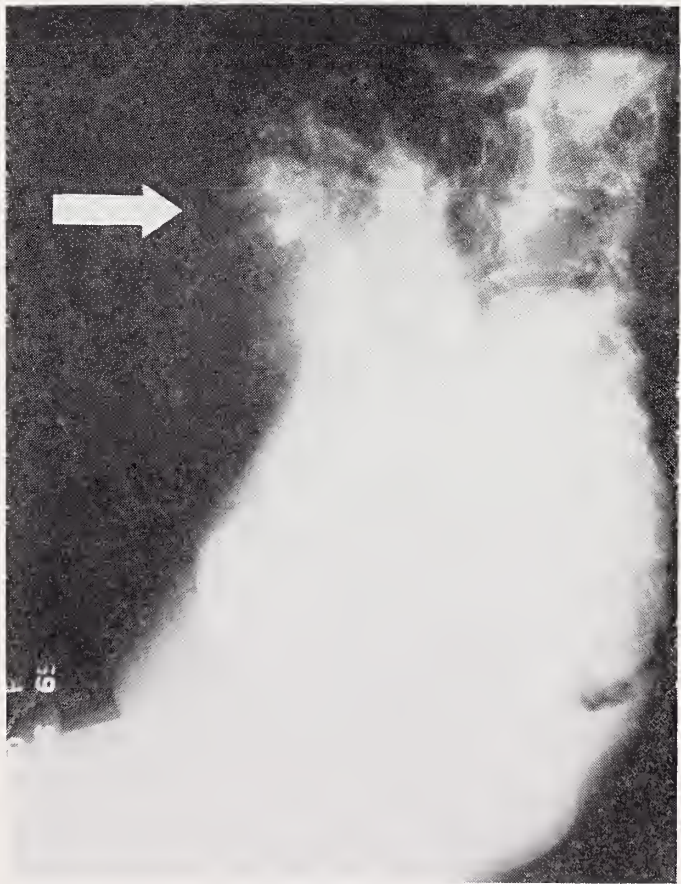


FIGURE 4

Lateral film of abdomen taken 4 hours after the injection of hypaque in the amniotic sac. It shows the contrast medium in the fetal intestines.



the administration of oxytocin as well as relaxant drugs<sup>10-11</sup> has been outlined.

In electrocardiography, the recording of the fetal EKG has been improved by the use of intrauterine leads.<sup>12</sup> An electrode is introduced in the amniotic cavity through an amniocentesis needle for closer contact with the fetus; its advantage is the elimination of skin resistance and noises originating in the abdominal wall of the mother. Chemical analysis of the amniotic fluid, intervillous space and sex determination of the fetus prior to delivery have all used amniocentesis.

This brief review of its current uses is by no means complete. More avenues of investigation, diagnosis and therapy will be forthcoming since more people are engaged in exploring this field of reproductive physiology.

## Summary and Conclusions

Amniocentesis in its present day status has been critically reviewed. Emphasis was placed on the technique and hazards. Under the heading of 1. Therapeutic, 2. Diagnostic and 3. Research—a variety of clinical applications are appraised. From the fore-

going it is evident that with the introduction of amniocentesis our knowledge on these aspects of reproductive physiology has become more dynamic and precise.

Department of OB-GYN  
Medical College of Georgia

## REFERENCES

1. Alvarez, H., and Caldeyro-Barcia, R.: Contractility of Human Uterus Recorded by New Methods; *Surgery, Gynecology & Obstetrics* 91:1, 1950.
2. Caldeyro-Barcia, R., and Poseiro, J. J.: Physiology of the Uterine Contraction; *Clinical Obstet. & Gynecol.* 3(2):386, 1960.
3. Csapo, A. I.: Progesterone Block; *Am. J. Anat.* 98:273, 1956.
4. Corner, G. W., and Allen, W. M.: Physiology of the Corpus Luteum; *Am. J. Physiology* 88:326, 1929.
5. Reynolds, S. R. M.: *Physiology of Uterus*, 2nd ed. New York, Hoeber, 1949.
6. Liley, A. W.: Amniocentesis Found to Halve Perinatal Loss in Rh Cases; *Obstet.-Gynecol. Observer* 2(3):7, 1963.
7. Queenan, John T., and Adams, Daniel W.: Amniocentesis: A Possible Immunizing Hazard; *Obstet. & Gynecol.* 24:530 1964.
8. Zipursky, A; Pollock, J.; Chown, B., and Israels, L. G.: Transplacental Fetal Hemorrhage After Placental Injury During Delivery or Amniocentesis; *Lancet* 2:493, 1963.
9. Liley, A. W.: Intrauterine Transfusion of Foetus in Haemolytic Disease; *Brit. Med. J.* 2:1107, 1963.
10. Talledo, E.; Adams, Suzanne F., and Zuspan, F. P.: Response of Pregnant Human Uterus to Oxytocin Given Intranasally; *J.A.M.A.* 189(5):348, 1964.
11. Talledo, E., and Zuspan, F. P.: In preparation.
12. Talledo, E., and Zuspan, F. P.: Fetal Electrocardiography: A Clinical Appraisal; *Clinical Medicine*. In press.

## GEORGIA PSYCHIATRIC ASSOCIATION FORMULATES STATEMENT OF POLICY

After due consideration, the Georgia Psychiatric Association has formulated this current Statement of Policy as regards the developing Mental Health Program for the State of Georgia.

1. The Georgia Psychiatric Association wishes to affirm its approval and support of the objectives and goals of the Division of Mental Health of the Department of Public Health. It also wishes to acknowledge its respect for the professional staffing and administrative direction of the Division.

2. It has high regard for Dr. Duval and his staff who have accepted the responsibility for this planning.

3. The GPA membership further offers their professional services in whatever way may be feasible to implement the plan designed to extend adequate psychiatric services to all citizens of Georgia.

The GPA recommends that major consideration be given to the development of psychiatric services where they are least available, with priority in all government sponsored programs to the provision of services to those who cannot afford private care.

5. It is the specific request of our membership to

the Mental Health Division of the Georgia Department of Public Health that the professional judgement and knowledge of local circumstances of the GPA psychiatrists be actively and directly sought and utilized in the formulation and implementation of future plans.

6. The GPA emphasizes that qualified personnel are the basic element of all mental health activities and urges and supports that programs for the training and recruitment of personnel be continued.

7. The GPA recommends that in-service promotion and placement policies be developed and publicized so that those presently employed in the State Service will be held and prospective employees will be attracted by the assurance of promotion as the individual becomes qualified for positions of increased responsibility, and openings occur.

8. The GPA recommends that its Past-Presidents' Committee meet with the executives of the Division of Mental Health each quarter and on call.

Formulated by the GPA Past-Presidents'  
Committee,  
Joseph Skobba, M.D., Chairman



# THE AIRWAY IN HEAD AND NECK SURGERY

Daniel B. Sullivan, M.D., *Augusta*

## ■ The author's experience with 211 cases is discussed.

THE AIRWAY, regardless of the anatomical locale of the surgery, is important. This goes without saying, and is realized by all people concerned with the act of surgery. Surgery confined to the area of the head and neck certainly does not change this, but it does present some problems which are different. The anesthesiologist and the surgeon are no longer separated by drapes and possibly a head stand. The working area for both then, becomes the same anatomical position. The surgery involved may change, dislocate, or irritate the airway, and it is because of this situation that the airway assumes a primary importance in the surgical procedure.

### Radical Surgical Procedures

The term, Head and Neck Surgery, as related to this paper, and from which the inferences and conclusions are drawn, are the so-called radical surgical procedures in and about the oral cavity and neck. They are usually neck dissections associated with combined intraoral procedures, with or without resection of mandible and/or maxilla. They may also include thyroid surgery with large, bulky tumors, either for benign or malignant disease. The principles of the airway involved in head and neck surgery, though, remain the same and some of the conclusions certainly can be carried over to surgery in the head and neck, regardless of the type of surgery that is involved.

In the past five years, we have operated on 211 patients who have had head and neck cancer, and it is from this group that our following thoughts are obtained. The airway in these individuals presents, actually, in three large groups:

- (1) Those people who present with an airway obstruction when they are first seen.
- (2) Those people who have a tumor in and about the head and neck, but who are not obstructed when they are first seen.

- (3) That group of individuals who do, or may develop airway obstruction in the post-operative state.

### Tracheostomy Tube

The first group, that is the group who present with an obstruction, actually solve their problem as far as the mechanical airway is concerned. This problem, of course, presents as an airway problem, and it is usually met by placing a tracheostomy tube to enable us to get the patient to surgery.

The tracheostomy is easily done in the operating room under local anesthesia and, if possible, with help, good light, and good instruments. One of the most important instruments in doing the tracheostomy is a single pronged hook to control the trachea as the airway is placed. The minimal size tube that we like to place in an adult is a No. 7 tube, and the type of tracheostomy tube we use is the Martin tube.

### Endotracheal Tube

The patient with the previously placed tracheostomy is taken to the operating room for definitive surgery, and the tracheostomy tube is replaced by a flexible endotracheal tube which is sutured in place and then swung over to the right or left, depending on the side of the surgery. The tube is prepped and draped in the open field. This may present a problem during the course of the surgical procedure if the larynx is to be removed, and most instances when one does this, the larynx is involved. If the tracheostomy tube has been previously placed in such a position that it would be necessary to remove the tube to remove the trachea, then one has to actually remove and replace the endotracheal tube during the procedure. This will vary, depending on when the patient is seen and who does the tracheostomy. The most pleasant situation would be if one could place the midline tracheostomy incision in the skin in the approximate position for the subsequent trachea

Presented at the 111th Annual Session of the Medical Association of Georgia, May 2, 1965, Augusta, Georgia.

stome and place the tube actually into the trachea within the first tracheal ring. This plan would allow the surgeon at the time of surgery to actually resect the larynx and the trachea without removing the endotracheal tube. If, however, it becomes necessary to change, move, or otherwise involve the endotracheal tube, a few words spoken between the anesthesiologist and the surgeon can settle a lot of problems immediately on the table, and we have experienced no real difficulty in our airway when it has to be moved.

### **A Choice of Three**

The second group of people, those who present with tumors of the head and neck but who have no airway obstruction, present us with a choice as to the type of airway and in most instances, the choices are three. These choices may be (1) the oral endotracheal, (2) the nasopharyngeal airway, and (3) pre-operative tracheostomy. The actual decision as to the type of airway is usually best arrived at with a discussion between the anesthesiologist and the surgeon. Each individual who is concerned directly with his own problem may have different ideas, and in our hands, not a formal discussion, but a few brief words have, in most instances, led us to an airway which is satisfactory during the procedure and post-operatively. The location of the tumor, the type of patient, and the amount of disease the patient has, will frequently lead us to a choice with not too much difficulty. There are some individuals in whom nasopharyngeal airways are the best, particularly if we do not plan to insert a tracheostomy tube post-operatively. These individuals would all have lesions that would be difficult to work with, with an endotracheal tube.

However, throughout the past several years, our use of nasopharyngeal airways has slowly but steadily decreased. The disadvantages of nasopharyngeal airways are simply that one may have difficulty in tubing the patient with a tube as large as desired, and in some instances bleeding ensues, which may be a problem both during the surgery and post-operatively.

It probably does reflect the type of cases we see, but pre-operatively tracheostomy performed on the table just prior to induction has replaced, in a number of instances, our nasopharyngeal airways.

### **Criteria for Selection**

In general, we may state that any patient who has had previous radical surgery on the neck or larynx or mandible, or who has had a large dose of radiation to one or both necks, or to the larynx, or who has had a previous tracheostomy, would fit into the cate-

gory of one who probably would need a tracheostomy tube at the completion of the procedure. In children whose airways are small, any work on the floor of the mouth, or in adults who have had work at the base of the tongue, or in whom one has to leave a pack in the pharynx, of course, tracheostomy is almost mandatory. When large tumors of the neck, or the thyroid, are removed, we sometimes see an almost complete flattening out of the airway, apparently due to compression atrophy of the cartilage, and in these individuals, tracheostomy is lifesaving.

### **Complications**

The complications of tracheostomy pre-operatively are infection and contamination, and recently there has been some evidence that pre-operative tracheostomy is a good bed for the growth of tumor, and apparently in one or two series has directly contributed to local peri-stomal recurrence. Bleeding and pneumothorax are complications also. The most common one in our hands has been bleeding. We have, in the past several years, placed silk sutures through the tracheal rings and brought them out through the tracheostomy skin site and kept them in place in case the tube has to be changed. This has been a help in one or two instances. There is one complication—the appearance is of severe nature, but the seriousness is not, and this is due to sewing the tracheostomy skin site closed without a place for egress of air. This may produce subcutaneous emphysema, which will subside spontaneously if the skin around the trachea tube is loosened.

### **Post-operative Benefits**

There have been several things that have helped our post-operative patient in the past several years, and these I will briefly name. The use of negative suction catheters rather than heavy pressure dressings has been of great value. The use of some of the enzymes prior to the surgical procedure, and then continuation for the next four or five days, has decreased some of the acute traumatic swelling that did occur in the first several days. This has not been true if the enzymes were started anytime after 24 to 48 hours.

### **General Considerations**

General considerations of importance to both the surgeon and the anesthesiologist that have to be mentioned in any discussion dealing with the airway, are the position and draping of the patient on the table. The patient should be positioned at the head of the table so the operating team can work around the head. The shoulders should be elevated and the table in reverse Trendelenburg about 10 degrees. The drapes should be as light and scant as possible over



the tube and the airway. This allows better control of the patient's airway.

In any instances of head and neck surgery where unusual conditions prevail or problems exist, the co-

operation of anesthesiologist and surgeon as to pre-induction can lead to better patient care while on the table, and during the post-operative status.

*1467 Harper Street*

## **EMORY UNIVERSITY ONE OF NINETEEN MEDICAL CENTERS IN U.S.A. TO STUDY LIFE-LONG MEDICAL RECORDS OF OLYMPIC ATHLETES**

The Olympic Medical Archives (O.M.A.) was conceived to improve the health of mankind throughout the world. World scientists have agreed that there is no better source of "maximum health" than the superfit young men and women gathered under the banner of the Olympic Games. A compilation of the life-long medical records—the OLYMPIC MEDICAL ARCHIVES—of many of the world's top athletes which will enable scientists to determine the long term effects of physical exercise on the health of man began with the 1964 Olympic Games in Tokyo.

### **Olympic Medical Library**

Today, just a little over a year later, Dr. Joseph B. Wolfe, International Chairman of the O.M.A. and medical director of the Valley Forge Medical Center and Heart Hospital, Norristown, Pennsylvania, reports that there are over 2,000 medical records and histories of athletes from some 20 countries filed in the O.M.A. Library of the Olympic Museum in Lausanne, Switzerland. These standardized physical examinations and questionnaires on personal, family, social background and athletic training programs of athletes from Belgium, Canada, Ceylon, Chile, Cuba, Czechoslovakia, Finland, Great Britain, Ireland, Japan, Mexico, Nigeria, Philippines, Nepal, Rhodesia, Taiwan, Trinidad, United States of America, Uruguay, U.S.S.R., Venezuela and Yugoslavia have been translated and coded on magnetic tape for electronic retrieval by qualified scientists and researchers.

In the past only sporadic investigations have been carried out on the effect of vigorous physical activity on man, which resulted in many contradictory conclusions in medical literature. With the aid of men like A. P. Richardson, M.D., Medical Coordinator of the O.M.A. in Georgia and the facilities offered by Emory University, it is hoped that the lifelong medical records of Olympic athletes will provide the answers to a number

of medical questions with wide implications. These studies may well shed light on:

1) The extent to which continuous, systematic, life-long vigorous physical activity prevents or retards the onset of some of the common diseases such as those of the heart and blood vessels; high blood pressure, chronic ailments of the joints and disturbances of the nervous system.

2) What types, duration and frequency of physical exercise are essential for maximum fitness.

3) What influence regular physical training has on longevity and morbidity.

### **Volunteer Corp for Science**

Dr. Richardson and his staff as well as other physicians, hospitals, medical and health organizations, Olympic contestants, their personal coaches, team coaches, trainers and participating members of the Olympic committees and sub-committees, have been enrolled in the O.M.A. Corp "Volunteers for Science." This group—all volunteers—during the past year has donated more than \$250,000 in time and service to promote the concept of the O.M.A.

The Olympic Medical Archives was developed by the American College of Sports Medicine and the program is now under the aspicues of its parent organizations, the Federation Internationale de Medecine Sportive, with the cooperation of the World Health Organization, the International Olympic Committee and the International Sports Federation.

The Executive Council of the Federation Internationale de Medecine Sportive (FIMS) which met in Magglingen, Switzerland, during the first week in October recently announced that plans are underway to enlarge the scope of the OLYMPIC MEDICAL ARCHIVES through the 1968 Games to be held in Mexico City.

## **CALL FOR SCIENTIFIC EXHIBITS**

**112TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA**

**Columbus, Georgia, May 8-10, 1966**

**For Information and Applications, Write to:**

**John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee  
938 Peachtree Street, N.E. • Atlanta, Georgia 30309**

# CONGENITAL ANOMALIES OF THE UPPER EXTREMITY

Frank H. Stelling, M.D., *Greenville, South Carolina*

- The psychological attitude of the parent is of greatest importance in the care of the child amputee.

THE SUBJECT of congenital anomalies encompasses a tremendous field of interest. I am limiting my subject to one small facet of this large field, that of congenital anomalies of the upper extremity. I do this not because of lack of interest in the other areas but for lack of time. Actually, my subject will be limited to the area of treatment. The main object will be that of indicating what our thoughts are about the treatment of many of these conditions at this time with relationships as to the type of treatment, timing of treatment, the magnitude involved in some instances, the possibilities and probabilities as to outcome and the all important psychological impact on the family and parents. The technical part of this therapeutic endeavor will be quite undetailed.

## Research in Genetics and Biochemistry

The field of research in genetics and biochemistry is the area of endeavor that will eventually solve the prevention of these problems which will be of greatest importance to all of us. In my field, we are at present utilizing methods and developing newer ones that will help the situation as it now exists just as we did in poliomyelitis, and hope that soon we will have discovered ways of preventing the problem.

It would be advisable at this point to give you a classification of the upper extremity anomalies, but to date the only thing that those in this field that are considered authorities can agree upon is that classification at this time is impossible. I shall therefore consider conditions that I feel important for one reason or another and discuss such particulars that would be helpful to you in diagnosis, referral and advice concerning the treatment of such cases.

Let us first consider the upper extremity deficiencies or those cases that are born with absence or par-

tial absence of the extremity. This group has been divided by Frantz and O'Rahilly into two large elements; (1) Transverse; (2) Paraxial. I shall now discuss only the transverse deformities which include amelia (absence of the entire extremity); Hemimelia, transverse, complete (absence of all but the arm to the elbow); Hemimelia, transverse, incomplete (absence of all except the arm and part of the forearm); Acheiria (absence of the hand and fingers); Phocomelia complete (absence of the arm and forearm with the hand articulating with the shoulder); Phocomelia proximal (absence of arm with the upper forearm articulating at the shoulder); Phocomelia distal (absence of forearm with the wrist articulating with the distal humerus at the elbow level). Adactylia and aphalangia will be considered elsewhere in this paper.

## Must Be Treated as Amputation

In all of these conditions the abnormality must be treated as amputation with or without surgical conversion. Naturally, the parents are going to be interested at first in only one solution, and that is the conversion of this to normal or near normal situation. This is impossible. To say this bluntly, although true, is a great shock, and there has already been one terrific psychological trauma in having a child with this deformity in the first place. The best solution is that of understanding and kindness and advice that orthopaedic consultation is advised at an early date. Let a little time heal the initial shock and arrange orthopaedic appointment sometime during the first two to three months. Except in very few instances, most of these cases are best treated in a well planned and staffed children's prosthetic clinic or center. Aitken and Frantz have frequently pointed out that to consider the child amputee as a miniature adult is to initiate disaster in the program of care.

Presented at the 111th Annual Session of the Medical Association of Georgia, May 3, 1965, Augusta, Georgia.



There are numerous problems and complications in the use and fitting of the prosthesis and training of the child amputee that do not exist in the adult and vice versa. One of the greatest of all problems that exists in the care of the child amputee is the psychological attitude of the parent. It is absolutely necessary to immediately establish rapport with the family and make it evident that a prosthesis is necessary and desirable. It is imperative that the family accept the prosthesis, and if this is done, the child will be no problem. The family must see that the child uses the prosthesis in practice until functional gain makes its use seem desirable. If the family is well indoctrinated, and all problems are carefully explained along with demonstration of function in similarly involved children, there will usually be little difficulty in their acceptance and cooperation. If this fails, the result will be poor.

### One of Surgical Complications

Bony overgrowth is one of the only surgical complications in children. Neuromata are seldom a problem, and phantom limb syndrome apparently is nonexistent. The age of fitting is a very important factor, particularly so in the unilateral deficiencies. Until recently, it was felt by most that a child could grow up and then decide for itself, but this was quite erroneous. If the child is allowed to do this, practically no unilateral case of the upper extremity will ever use a prosthesis. Later, it was felt that the prosthetic fitting just before school age was ideal, but now it is known that prosthetic tolerance and functional use are attained as young as six months. Purposeful grasp and release activity is seldom attained earlier than 24 to 30 months. Standard fitting with good functional results and prosthetic acceptance may be nearly universally obtained at ages four to four and one half years.

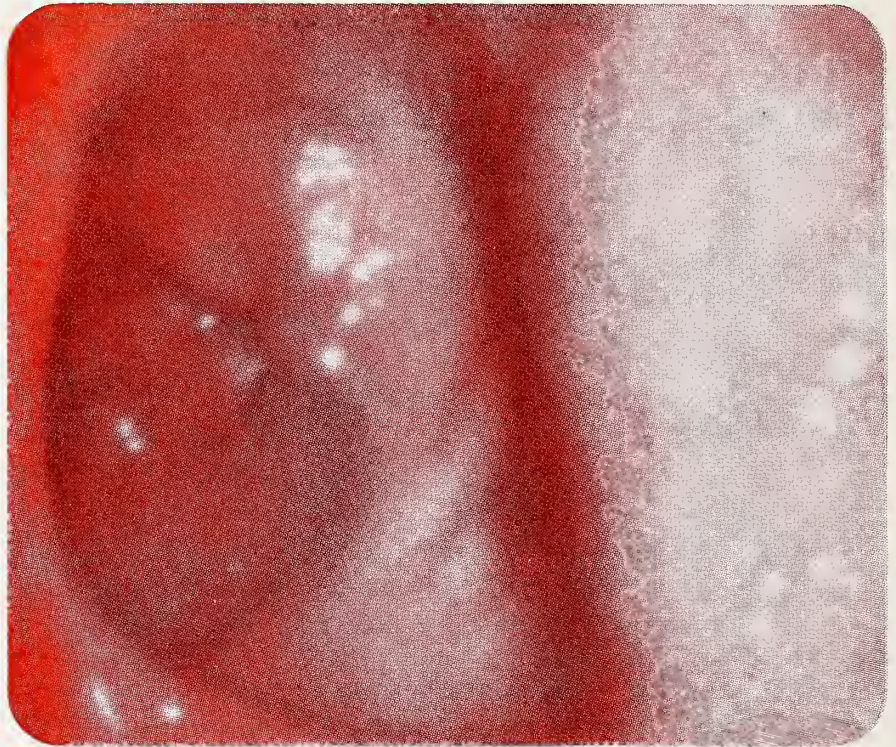
### Radial Hemimelia

The term clubhand is a descriptive one which has been used in the literature to denote a deformity manifested by radial deviation of the hand and hypoplasia of the forearm and hand, often with failure of development of the thumb. In these cases there is either a failure of development of the radius or at least only a partial development of the radius. As Frantz and Aitken have pointed out, the use of the word clubhand is somewhat confusing, does not describe the entire condition nor does aplasia or hypoplasia of the radius, which indicates only the bony part of the abnormality, really describe the condition; therefore, they advised that we use the term radial hemimelia, longitudinal, paraxial, which means that the entire radial part of the forearm is deficient including the radial part of the hand which usually

is manifested by absence of the thumb. This is distinguished from the intercalary type of radial hemimelia whereby there is a normal hand, and only the radial element itself is absent. In nearly all of these cases, there are associated anomalies in the skeleton and other parts of the body. There are often vascular changes and in nearly every instance abnormalities in the vascular tree and in the nerve development to the part itself. In many instances there are also associated cardiac defects with septal defects, particularly. In reviewing the literature through the years, many types of operative treatment have been advocated for the treatment of these conditions, but probably in most instances the decision has been mainly that of leaving well enough alone. Even now surgical treatment is advocated in some instances but not always. The age of the patient is all important. In instances, particularly in the male, whereby the child has developed to the age of eight or nine or more and has good functional use of the extremity, particularly if it is bilateral, I think that it is best to leave these children alone. Cosmetically they might be improved but only to the disadvantage of the child of losing some of its function. In a female, one might desire a little better cosmetic result rather than push too much for the dexterity. Conservative treatment per se is of little value. Utilization of splints and casts to stretch out tight skin prior to doing the underlying bone, ligamentous and muscular work is of advantage, but to stretch this out, splint it and then let it go will only result in return of the original deformity. For several years, we have performed the so-called Riordan modification of the Starr procedure to some advantage. At first we felt as Riordan did that these cases would do well right on into adult life. The upper end of the fibula is dissected out and grafted to either the remaining elements of the upper radius, if this is present, or spliced into the radial side of the ulna, hoping the epiphysis would grow out. In a few instances this happened, and the child developed certainly a better hand and forearm, but they did continue to remain somewhat hypoplastic, and in many instances, the radius did not keep up and acted as a further element of holding back so that radial deviation of the hand recurred to some extent. Riordan has had enough experience now to have written a new paper advocating that his original idea about this be discontinued. He now finds that by doing an early procedure of soft tissue dissection both from the lateral and the medial aspect of the wrist that the carpus is completely loosened from the radial side of the distal ulna. The hand is then transferred over the articular or epiphyseal end of the ulna, fixed in this position with a Kirschner wire and held for a number of weeks, the Kirschner wire then being removed and the hand being splinted usually

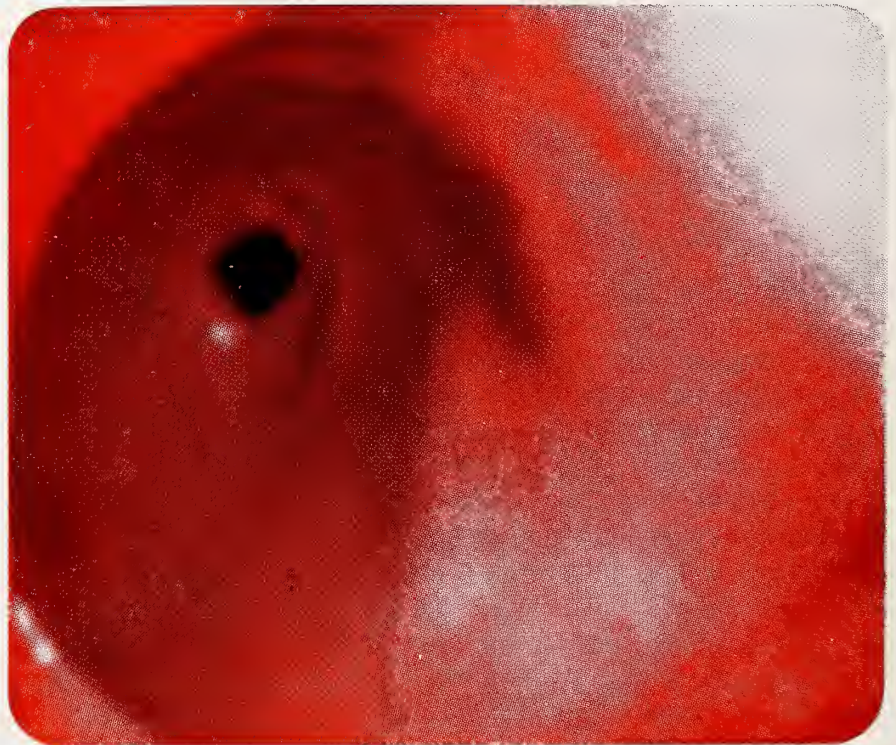


## Intragastric photography studies<sup>1</sup>



**A/** E. B., male, age 48. Normal antral contraction. Pyloric opening is not seen. It is difficult to differentiate a deep prepyloric contraction from a "pyloric fleurette" or true pylorus.

**B/** Same subject after 6 mg. of propantheline bromide intravenously; antral contractions ceased. The pyloric orifice remained open and was easily identified. Better visualization of the antrum was also obtained.





# Now you can see Pro-Banthine® at work

(propantheline bromide)

Pro-Banthine is so effective in anticholinergic action that it may be employed in visualizing the entire pyloric region.

In addition to the intragastric photographs, cinegastroscopic studies<sup>2</sup> have demonstrated graphically not only its effectiveness but the superiority of Pro-Banthine over belladonna alkaloids.

Pro-Banthine produced complete cessation of gastric, antral and pyloric motor activity with a dose of 6 mg. intravenously. This is approximately one-third the usual oral dose of 15 mg.

Atropine at full normal dosages did not produce such cessation. It required double the usual oral dose of atropine, 0.8 mg. intravenously, to duplicate the aperistaltic action of Pro-Banthine. This dose of atropine produced pronounced discomfort and tachycardia with ventricular rates as high as 150 per minute.

It is this pharmacologic superior-

ity of Pro-Banthine which has made it the most widely prescribed anticholinergic in such conditions as peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

**Dosage**—The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15 mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily.

**Side Effects and Contraindications**—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

**SEARLE**

*Research in the Service of Medicine*

with some type of plastic splints for many, many months so that the ulna will hypertrophy at its distal end, and finally the wrist will align and develop in a nice normal longitudinal direction over a hypertrophied new epiphysis of the ulna which articulates with the carpus. Riordan feels that this should be done at a very early age, even before six months, if we can see the patients this early. We have done a few of these, have not studied them as long as Riordan has as yet and not long enough to really give final results, but so far, this looks as though this is going to be the most promising of all procedures as yet undertaken. The ulnar epiphysis has shown hypertrophy, and the wrist and hand do remain aligned distal to the ulna, and there are no abnormal structures which tend to shift this off by lack of growth. I feel that good results can be obtained in some instances if this same procedure is done in little older age groups even up to early school age, but after this, I feel that it is best that we leave this alone because these children do tend to adapt themselves to this and develop better function than if this is interfered with by an attempted procedure such as this at a later date. Of course, if cosmetics are looked for, the wrist can be tightened and some of the functional loss can be accepted.

### Syndactylism

Syndactylism is a condition whereby it is felt that there is a failure of segmentation in the limb bud. This may occur in failure of segmentation of the soft tissues or just the skin, or in some instances actually failure in segmentation of the bony parts also. This leads us away from the deficiencies which we have just been discussing and now brings us into a realm of anomalies that is very difficult to classify. The main anomaly, of course, is the failure of segmentation, but this is also associated in many instances with additional parts or polydactylia or even parts of additional bones that sometimes have very anomalous articulations within the hand. Often very bizarre anomalies are present. There may even be deficiencies present in this condition. In many instances there is an accompanying brachydactylia or hypoplasia of all or some of the elements of the hand or fingers. Sometimes there is an accompanying symphalangism or failure of segmentation of the phalanges in a longitudinal direction. It is quite evident from this description that no one prognosis can be given for all cases of syndactylism. The final prognosis in many instances of multiple congenital anomalies depends upon what we have to work with in the first place. Sometimes with a combination of basic procedures including the separation of the

fingers, the subtraction of additional anomalous parts or even at times transposition of certain parts is required to give a final solution to the problem. In other instances, simple separation of the skin and skin grafting which will be described are the only things necessary, and the prognosis will be quite excellent. Each case must be considered individually, and after the surgeon has decided on his complete and total plan of treatment, this must be clearly stated to the family so that everyone has the proper idea as to exactly what one is working for and what the final object will be.

### Procedure for Separation of Fingers

The basic procedure utilized for the separation of the fingers is certainly not original with me and has previously been described quite well in Bunnell's *Surgery of the Hand* and in other surgical textbooks such as Campbell's *Textbook of Orthopaedic Surgery* and Ferguson's textbook of *Orthopaedic Surgery in Infancy and Childhood*. The fingers are separated by zigzag incision both on the volar and dorsal aspect, splitting through the nail and making a V-shaped flap with the base toward the metacarpal heads on both sides. The "V" is crossed, suturing usually with very fine chromic catgut so that these sutures do not have to be removed at a later date, and then inlaying a thick split thickness skin graft to cover the raw areas on each side of the fingers. Only two fingers should be released at any one time. This should be done under a tourniquet, and the tourniquet should always be released before covering. The end result is going to depend largely on how immobile one can keep the fingers during the period necessary for the actual "taking" of the skin graft which lasts approximately three weeks. The more complete the "take," the less scarring and better end-result one will have. It is very difficult to immobilize the hand of an infant. Even in plaster casts with a tremendous amount of splinting, these children are usually able to work the fingers free and often lose parts of the graft. For this reason, it is felt that if there is no discrepancy in the length of the fingers, it is well to delay these separation procedures until the child is about four years of age. In case of marked discrepancy in the length of the fingers such as the little finger and the ring finger, then one must take one's chances and do the best that one can at an early age. This should be done under the age of one in order to prevent increasing deformity with the growth of the two fingers. Immobilization is usually continued for a period of approximately six to eight weeks with the fingers completely straight, which is different from what one would do for splinting an adult. This can be done in children with no deleterious effects on the joints, ligaments and muscular



attachments which would ordinarily lead to stiffness and tightness in the adult. In some instances if immobilization is not secure and motion occurs, there will be varying degrees of loss of skin graft with scarring and frequently longitudinal scarring along the flexor aspect of the finger, causing skin contraction of the flexion type. If this does occur, Z-plasties or skin graft inlays of split thickness skin can be utilized with very good results. This must be done before joint or bone deformities occur. In some instances there has been evidence of an additional finger within the skin folds of syndactylism, and often the additional finger is the middle one between the two more normal ones, and this can be removed at the time of the separation, being sure to remove all of the abnormal part and also being sure to leave fingers that have functional elements such as the tendons, nerves and vessels, and the closure can be performed in the usual basic way of closing a syndactylia with the addition of skin graft. Occasionally there are so many abnormal bony elements in one of the fingers that deletion is definitely necessary in order to improve the function of the hand. If this is necessary, it can be done instead of separating and use the skin from the extra finger for closure rather than doing a skin graft. This should certainly be discussed with the family before surgery. If there is any feeling that there is not complete certainty of function, it is best to separate it and then do the deletion sometime later. If the finger to be deleted at a later date is the ring or middle finger, one may certainly want to jog the index finger and the distal end of the second metacarpal to the third metacarpal shaft or the little finger, including the distal end of the fifth metacarpal over to the fourth metacarpal shaft, as the case may be. This will depend to a great extent upon the particular normal elements that are present at that time and will have to be left to the experience and decision of the surgeon doing this work.

### Polydactylism

Polydactylism is a third broad subject of classification of these hand anomalies, and in itself actually means very little other than that there are extra parts. These are numerous and often associated again with other anomalies just as syndactylism. We also again enter the realm of difficulty with classification because we can have not only duplication or an increased number of parts but at the same time actually a failure of the proper number of parts. This is seen in the so-called "mirror hand" or duplication of fingers. Actually, these should be called ulna dimelias. The patient has two ulnas, absence of both radii and absence of the thumb but duplication of the ulnar elements of the hand; the patient often

having six to eight fingers. This is a very rare anomaly, and fortunately, we do not have to deal with this too frequently. Treatment would entail the removal of parts that are unnecessary and unsightly followed by transposition of an extra finger to take the place of the thumb. Polydactylism is probably the most common of all anomalies although it has not been described, being felt to be the most common, however. In many instances of polydactylism where there is only a small skin pedicle, this is taken care of in the nursery. We never see these cases and statistics are misleading. Before removing parts whereby there are definite additional parts present, one must be certain that the part that is being removed is the part that should be removed and that it really is of less function than any of the other parts present. This is often not very difficult to determine since frequently one of the extra parts is hypoplastic and not well formed, and it is very easy to make the decision; however, in other instances, there may be six fingers and all six seemingly appear to be the same and also seemingly function the same, and here the decision must be made from a cosmetic standpoint. In the case of the thumb, the abnormalities present vary greatly. We may see a bifid distal phalanx or even a double distal and proximal phalanx, and in some instances an entire double ray. In the case of the double distal phalanx, there has been an operation described in the literature whereby a zigzag is made in the skin, the nail and the bone and the two parts placed together, and if this is done at an early age, there is very great likelihood that the epiphyseal growth will be disturbed and rather marked deformity will occur, and I would not advocate this procedure. If one does desire to get good closure of the defect and the two parts are quite close together, one might perform a removal of the opposing skin and close the defect, bringing the two small bones together and giving a broad based thumb with good sensation and a little cleft nail. Actually, a syndactylia is produced. If this works fine, one might desire to leave well enough alone as the child matures; however, if at some later date one desires to redo this after epiphyseal growth has completed itself, then this would be the time to perform this procedure. In those instances where the entire thumb is duplicated, one must make the decision as to which has the best functional elements present and delete the one that is less functional. In other instances, the proximal and distal phalanx are duplicated, and one sometimes has to make the decision as to which of these actually has the proper muscle attachments, and sometimes the best one is the ulnar thumb. If this is left in place while the radial thumb has been removed, one must be certain that the muscle attachments are transferred to the remaining thumb so that



we get proper function at a later date. These things should all be considered rather than just going in and operating on the x-ray, considering only the bone and cartilaginous elements.

### Congenital Absence of the Thumb

I have previously mentioned the transposition of an index finger to take the place of a thumb which can be done and with quite excellent functional and cosmetic results. This can be done at any age; however, if this is done in congenital anomalies it is well to do this at a very early age, if one desires to get the best cosmetic and functional result possible. Usually, this is not advocated except in the bilateral cases. We utilize a procedure which has been described by Littler with modifications with quite excellent results; however, we have had difficulty controlling the proper intrinsic function at the new metacarpophalangeal joint, and in a few cases have added an opponens transfer which has given us much better stability. Recently, however, Littler has described an addition to his previous procedures whereby he changes the direction of the intrinsic mechanisms by transferring the common extensor tendon and shortening and dividing the lateral bands so that the function of the abductor and adductor pollicis is more or less duplicated. This is a rather nice technical feat which I will not explain in detail in this paper, but only mention that with the utilization of this new technique, the end functional results are much better than any that we have had before. The moving of the index finger to duplicate the function of the thumb is by far the best procedure to be used of all that have been advocated in the past. One is able to provide a better functional movable part with maintenance of the circulation and good sensation. This is much preferred to a post or a quite short hypoplastic thumb which is actually in the wrong place to give good function. If a little hypoplastic or atavistic thumb is present, these are best removed and the index finger pollicized for congenital absences of the thumb. Prior to doing any of the surgery, there must certainly be tremendous rapport between the doctor and the parents, and the parents should understand quite well the complications that could occur prior to performing such surgery.

### Cleft Hand

These are actually variations of adactylia and aphalangia. The cleft hand is a rare deformity with tremendous variations, which is also usually accompanied by many other congenital malformations such as syndactylism, brachydactylism, symphalangism. The usual deformity is that of a central cleft

dividing the hand into two parts. Sometimes there may be only two digits with a very small cleft between. In such instances, one may desire to shorten and transpose one of these digits. We have discussed this under congenital absence of the thumb. The idea is to try to get a pincer action by having the parts oppose one another. In other instances where the cleft is present and normal finger function is present on each side, one may desire to close the cleft which can be done fairly easily from a technical standpoint.

### Congenital Grooves and Bands

These are peculiar anomalies infrequently seen which are often multiple and involve usually more than one extremity. They are present at birth and are often accompanied by single or multiple absence of parts. The absence of parts in these instances is considered by most authorities to be due to interference with vascularity in utero by the constricting band so that the part distal becomes gangrenous. There have been instances reported in the literature of the amputated part being present separate from the fetus at birth.

The grooves or bands may vary considerably in severity. If there is only a slight indentation without interference with function and cosmetically acceptable it should be ignored. If the constriction is removed surgically, the entire band should be removed down to normal tissue. Often the fascia is involved, and this should be released also. Closure should be performed by multiple Z-plasties. If the band is circumferential, as most of them are, it should be removed in two or three stages. The surgery can be done at any age and is usually performed as an elective procedure. If a part distal to a band begins to show increasing edema, this usually is an impending sign of disaster. The lymphatics and venous structures will soon become involved, and there will be gangrene and loss of the part. In such instances with increasing size distal to the band, surgery should be considered as an emergency. If part of the band is removed at this time, there will be a rather quick improvement, and the part distal will return to normal size avoiding the loss of the distal part.

### Summary

This discussion has dealt principally with the treatment of some of the congenital anomalies of the upper extremity. The anomalies discussed were divided into those of (1) deficiency of parts; (2) addition of parts; (3) failures of segmentation of parts; (4) abnormal division of parts; (5) congenital bands and grooves; and (6) combinations. The actual detail of technique was not attempted. Emphasis was placed on treatment in relationship to timing of consultation, timing of surgery, type of treatment, the magnitude, probabilities and possi-



bilities of prognosis and the psychological impact upon the child and the family.

9 Medical Court

BIBLIOGRAPHY

1. Aitken, G. T., and Frantz, C. H.: Congenital Amputation of the Forearm; *Ann. Surg.* 141:519, 1955.  
2. Aitken, G. T., and Frantz, C. H.: Management of Child Amputee, Instructional Course Lecture, A.A.O.S., V-XVII, 1960 (C. V. Mosby Co., St. Louis, 1960).  
3. Barsky, A. J.: Congenital Anomalies of the Hand; *J. Bone & Joint Surg.* 33-A:35, 1951.  
4. Bunnell, Sterling: *Surgery of the Hand*; J. B. Lippincott Co., 1944.

5. Frantz, C. H., and O'Rahilly, R.: Congenital Skeletal Limb Deficiencies; *J. Bone & Joint Surg.* 43-A (No. 8):1202, 1962.  
6. Littler, J. W.: The Neurovascular Pedicle Method of Digital Transposition for Reconstruction of Thumb; *Plastic & Reconstruction Surg.* 12:303, 1953.  
7. MacCollum, D. W.: Webbed Fingers; *Surg. Gynec. & Obst.* 71:782, 1940.  
8. Riordan, D. C.: Congenital Absence of the Radius; *J. Bone & Joint Surg.* 37-A:1129, 1955.  
9. Stelling, F. H.: Surgery of the Hand in the Child, Instructional Course Lecture; Am. Academy of Orthop. Surg., 15:172, 1958.  
10. Stelling, F. H.: Surgery of the Hand in the Child, Instructional Course Lecture, Am. Academy of Orthop. Surg.; *J. Bone & Joint Surg.*, Vol. 45-A, No. 3, 623-541, April 1963.

1966 CALENDAR OF MEETINGS

State

Postgraduate Courses sponsored by the Department of Continuing Education of the Medical College of Georgia, Augusta.

- January 12-March 30—Psychosomatic Medicine follow-up course (12 weekly evening sessions).  
January 18-19—Common Metabolic Disorders  
January 25-26—Pediatrics  
February 22-23—Obstetrics and Gynecology  
March 10—The Adolescent Girl  
March 24-25—Trauma  
December 7-May 12—Georgia Circuit Courses (six sessions, one day each month at six centers in Georgia).

March 15-19—Postgraduate Seminar in "Fundamentals of Otolaryngologic Allergy," sponsored by the University of Tennessee College of Medicine, Memphis, Tenn.

March 16-18—A Symposium on "Clinical Aspects of Renal-Endocrine Interactions," presented by the Department of Medicine, Emory University School of Medicine, Grady Hospital Auditorium, Atlanta, Ga.

April 4-8—39th Annual Spring Congress in Ophthalmology and Otolaryngology sponsored by The Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va.

April 13-16—19th Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Va.

April 14-16—Annual Meeting of the Georgia Society of Ophthalmology and Otolaryngology, Grand Bahama Hotel, Grand Bahama Island.

May 5-7—Ninth Biennial Cardiovascular Seminar, "Newer Methods in Ischemic Heart Disease," presented by the Section of Cardiology, University of Miami School of Medicine and the Heart Association of Greater Miami, Carillon Hotel, Miami Beach, Fla.

May 8-10—112th Annual Session of the Medical Association of Georgia, Columbus, Ga.

Regional

September 15, 1965-June 15, 1966—A nine month tutorial program in Cardiology offered by the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

January 10-14—American College of Physicians, Postgraduate Course No. 9, Internal Medicine, "Medicine of Tomorrow: Recent Advances in Internal Medicine," University of Alabama Medical Center, Birmingham, Ala.

January 13-15—American College of Surgeons Sectional Meeting, Bal Harbour, Fla.

January 16-22—Postgraduate Medical Education, "General Practice Review," sponsored by the University of Colorado School of Medicine, Denver, Colo.

January 28-30—Southern Radiological Conference, Grand Hotel, Point Clear, Fla.

January 31-February 2—American College of Surgeons Sectional Meeting, Houston, Tex.

February 7-9—Atlanta Graduate Medical Assembly, Mariott Motor Hotel, Atlanta.

February 28-March 3—Southeastern Surgical Congress, Mariott Motor Hotel, Atlanta, Ga.

February 28-March 4—Seminar in Obstetrics and Gynecology. Cruise to Nassau and Freeport in the Bahamas, S.S. *Ariadne*. Sailing from Ft. Lauderdale, Fla. Presented by the Dept. of Obstetrics and Gynecology, College of Medicine, University of Florida. Approved by Florida State Board of Health, Florida Medical Association, and Florida Academy of General Practice.

March 7-10—New Orleans Graduate Medical Assembly (29th Annual), The Roosevelt Hotel, New Orleans, La.

March 21-23—Dallas Southern Clinical Society, Statler-Hilton Hotel, Dallas, Tex.

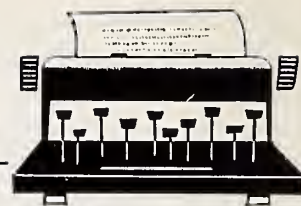
National

February 27-March 4—International Anesthesia Research Society (40th Congress), Americana Hotel, Bal Harbour, Fla.

March 23-25—American Surgical Association, Boca Raton, Hotel, Boca Raton, Fla.

May 23-25—Annual Meeting of the American Thoracic Society, Medical Section of the National Tuberculosis Association, San Francisco, Calif.

June 26-30—American Medical Association Annual Convention, Chicago.



## A Physician's Christmas Story

**I**N THE CHRISTMAS season, people around the world will read and love the Christmas story. Much of it comes to us from Luke whom Paul called "the beloved physician."

We are indebted to Luke for the account of the wonderful events accompanying the birth of John the Baptist. He tells the story of Gabriel's visit to Mary and of her excited visit to her cousin, Elizabeth. Luke gives us her song of praise. It is Luke that wrote down the tender story of the birth of Jesus. He leads us to the crib where the young Christ lay to join the shepherds in adoration. How much the world has gained from the heart and hand of this physician.

In time he became attached to Paul and to the Christian faith. He expressed his faith by his service to Paul as personal physician. In this service he became familiar with the life of Jesus and was prepared to write it down for the blessing of the ages.

Perhaps here is a true example of the meaning of Christmas. Here was one who served his friend's need of a physician because of what Jesus Christ had done for him. By doing this, he helped make possible Paul's monumental work. But also he, himself, was used to bring untold blessing to mankind.

Part of the meaning of Christmas is encouragement to all who serve others. If Christ is in the service, it will help others to do their work, and it will enable the one who serves to grow in grace and character to serve ever more fruitfully.

*Vernon S. Broyles, Jr., Th.D., D.D.  
Minister, North Avenue Presbyterian Church  
Atlanta, Georgia*

## Medicare Rules Soon To Be Determined

**A**T THE PRESENT time there is little that can be said definitely about the rules and regulations currently being promulgated by the Department of Health, Education and Welfare under the provisions of the new "Medicare" law—in that the final policies and plans are still on the drafting board.

However, certain information bears emphasis in keeping informed on all developments relative to P.L. 89-97. The State Department of Public Health has been designated to assist HEW in determining standards for institutions wishing to participate in the "Medicare" program such as hospital, nursing homes, etc.

Under Part A (Hospital Benefits) of P.L. 89-97,

HEW will select the fiscal intermediary to receive and pay bills for services rendered to eligible recipients. In addition, the fiscal intermediary will determine the reasonable costs for services furnished and assist providers of services in maintaining utilization safeguards on services available.

### "Carrier" as Intermediary

Under Part B (Medical Benefits), HEW will select a "Carrier" to act as intermediary and this "Carrier" will make determinations of the rates and amounts of payments to be made to physicians and others—on the basis of reasonable charges. The "Carrier" will receive, disburse and account for funds



in making payments by contract with HEW under the provisions of P.L. 89-97. The "Carrier" will also serve as a channel of communication to and for providers of health care. Whether the "Carrier" will serve on a regional basis, a statewide basis or whether a number of "Carriers" will serve within a single state has not been clarified.

The Medical Association of Georgia, on the recommendation of the Executive Committee of Council, has made application to HEW to function in the capacity of "Carrier" under Part B, P.L. 89-97. HEW has received well over 100 applications for Part B from private insurance companies and Blue Shield plans.

It should also be emphasized that under Part B (Medical Benefits) of the "Medicare" law, the physician will have two options for payment for services rendered eligible recipients as follows:

(1) being paid by the "Carrier" on the basis of an assignment under the terms of which the reasonable charge is the full charge for the service as determined by the "Carrier," or

(2) being paid by the patient in full and furnishing the patient a receipted bill so that the patient may be reimbursed by the "Carrier" on the basis of reasonable charge as determined by the "Carrier."

Under Part B, all charges are subject to an annual \$50.00 deductible paid by the patient with the program then paying 80% of the reasonable charge—and the patient paying the remaining 20%.

### Problems Under Study

The administrative problems of standards, utilization review, carriers and reasonable charges are presently under study by HEW. HEW is now meeting with representatives of all concerned organizations, and the wheels of consensus grind slowly. Further discussion at this time can only be speculative and without fact. MAG is awaiting further information on these many questions so that it can properly communicate data on "Medicare" to the doctors of Georgia through the Association Journal, the MAG County Medical Society Newsletter and by special mailings.

## 1966 ATLANTA GRADUATE MEDICAL ASSEMBLY TO BE HELD AT MARRIOTT MOTOR HOTEL, FEBRUARY 7, 8 AND 9

The 1966 Atlanta Graduate Medical Assembly will be convened February 7, 8 and 9 at the new Atlanta Marriott Motor Hotel.

The faculty of eighteen speakers has been carefully chosen and will present an outstanding three-day course in each of the major specialties and some of the subspecialties. A brief outline of the program is as follows:

*Monday, February 7—A Day of Medicine*

#### FACULTY:

E. B. Astwood, M.D., Pratt Clinic, Boston  
William A. Steiger, M.D., Temple University  
Morris Ziff, M.D., University of Texas  
(Dr. Ziff sponsored by the Arthritis Foundation)  
J. Arnold Bargen, M.D., Scott and White Clinic,  
Temple, Texas  
Leon Schiff, M.D., Cincinnati General Hospital  
(Dr. Schiff sponsored by Atlanta Clinical Society)

*Tuesday, February 8—A Day of Cardiology*  
(Sponsored by the Georgia Heart Association)

#### FACULTY:

David A. Rytand, M.D., Stanford University  
Neal S. Bricker, M.D., Washington University  
Herman K. Hellerstein, M.D., Cleveland, Ohio  
Frank Gerbode, M.D., Presbyterian Medical Center

*Tuesday, February 8—A Day of Surgery*  
(Sponsored jointly by Georgia Chapter, American  
College of Surgeons and the Atlanta  
Graduate Medical Assembly)

#### FACULTY:

Howard Mahorner, M.D., Mahorner Clinic, New  
Orleans

James D. Hardy, M.D., University of Mississippi  
G. Rainey Williams, M.D., University of Oklahoma  
Charles C. Harrold, M.D., New York  
Tom Shires, M.D., University of Texas

*Wednesday, February 9—A Day of Obstetrics,  
Gynecology, Pediatrics and Orthopedics*

#### FACULTY:

Roy G. Holly, M.D., Jefferson Medical College—  
Obstetrics  
Kermit E. Krantz, M.D., University of Kansas—  
Gynecology  
Robert J. Haggerty, M.D., University of Rochester—  
Pediatrics  
A. H. Crenshaw, M.D., Campbell Clinic, Memphis,  
Tenn.—Orthopedics

Luncheons at the Marriott are planned each day. The William H. Rorer Hospitality Lounge will be open from 9:00 to 4:30 p.m. daily.

There will be 101 technical exhibits as well as scientific exhibits.

Entertainment for the wives is planned by the Ladies' Activities Committee.

If you plan to stay at the Marriott, please make reservations early. For information contact Mrs. B. W. Shafer, Atlanta Graduate Medical Assembly, 875 West Peachtree Street, N.E., Atlanta, Georgia 30309, or a member of the Committee: Frank L. Wilson, Jr., M.D., Chairman; George S. Roach, Jr., M.D.; William J. Pendergrast, M.D.; F. W. Dowda, M.D.; and J. Gordon Barrow, M.D.



## THE HARVEST SEASON, THANKSGIVING AND CHRISTMAS

CALL IT WHAT YOU MAY—Whether it be Autumn, Indian Summer or whatever name—the Fall of the year perhaps has always been my favorite season.

I like to think back to my boyhood to the time when the weather was getting cooler and the days shorter.

We would get out to play in the afternoons after school—it was nice to get out in the sharp fall atmosphere and skate or play such games as football. Naturally, we would stay out as long as our parents would allow. Quite often on the way home the aroma of cooking ham or sausage was very noticeable as some of the neighbors' homes were passed. It never failed to whet appetites. You can tell that I have always liked to eat.

Good things can't last, so it was to home and study after supper and no television.

### A Special Event

While reminiscing, one can't help but remember that when the first real cold weather came, hogs were generally killed. What an event it was to watch the meat being cut up and salted down—that is after getting home from school. Perhaps a hand might be lent at grinding or stuffing the sausage and then finally to have the pleasure of helping sample to see if the seasoning had been done properly.

Fall time always brings recollections of the colorful leaves and the harvesting and marketing of the crops which had been planted and tilled during the months before.

Thinking of the Harvest Season, I cannot help but be reminded that we in the Medical Association of Georgia are now in a Harvest Season. One of the nicest crops we have is the result of the Medical Education Conference last January. We are now beginning to harvest a series of "Circuit Riding" courses. These courses were begun this December and will continue through May, 1966. They are being conducted by the faculty of the Medical College of Georgia, in cooperation with the Medical Association of Georgia and the Georgia Academy of General Practice. These are one day courses extending from early afternoon into the evening. They are being held at six strategically located places over the state and concern six different areas of interest.

I do not mean to imply that MAG is trying to take all the credit for these courses, but it is my feeling

that the process of setting them up was stimulated by the Medical Education Conference.

Emory University School of Medicine is also offering a wide variety of courses on campus through the academic year. In addition, the MCG is offering a number of on-campus courses.

We should show our interest and appreciation by making a real effort to "harvest" as much of this "Educational Crop" as we possibly can. More than anything else, this will encourage the schools to continue to provide good courses.

On the other side of the picture—we, as much as we dislike it, will have to think of the weeds. Naturally, as most of us, if not all, see it, "Medicare" is the worst weed with which we must cope. Despite all the efforts of American Medicine and its friends, plus the use of "weed killing hormones" and poisons, the "Medicare weed" progressed to maturity. We are now confronted with the problem of living with it and trying to control its seed. As physicians and Americans, we must recognize that it is the "law of the land" and that live with it we must. However, we should continue to work to change the law as indicated to remedy its defects and make it less unpalatable.

Despite Medicare and its ramifications, there was much at the Thanksgiving Season for which we had reason to be thankful. Many things—spiritual and material—and pertaining not only to us and our profession, but also pertaining to our country and our way of life gave us, and I hope will continue to give us, reason to be truly THANKFUL.

Now that another Holiday Season approaches, let us, to Thankful Hearts, add in full measure the feeling of the True Christmas Spirit, which is Joy, Love and Good Will. May you find much happiness with families and friends.

During the New Year, may you try to live each day so as to increase the feeling of Good Will Among Men. In this way, we might hope eventually for Peace among men.

MERRY CHRISTMAS AND HAPPY NEW YEAR!

George H. Alexander, M.D.  
President, Medical Association of Georgia



# Announcing **EUTRON™**

pargyline hydrochloride 25 mg. and methyclothiazide 5 mg.

for control of  
moderate to severe  
hypertension

## **Unique combination produces greater antihypertensive effect with lower doses**

Eutron is the combination in a single tablet of 25 mg. Eutonyl (pargyline hydrochloride) and 5 mg. Enduron (methyclothiazide). This combination produces greater therapeutic effect than that of either component used alone. Side effects may be milder, too, as dosages are generally lower. The effective dosage is usually one tablet, once daily. Tablets are scored for greater dosage flexibility.



Each Eutron tablet contains two proven antihypertensives  
in the ratio shown to be most effective in most patients.

TM—TRADEMARK

New **EUTRON**  
extends your range  
of treatment in  
moderate to severe  
hypertension

A single product  
you can use even  
in the presence  
of congestive heart  
failure or edema

**Eight out of 10 patients respond**

In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.<sup>1,2,3</sup> The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.



1. Torosdag, S., Schwartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, *Am. J. Cardiol.*, 12:822, Dec., 1963.

2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, *Cur. Thera. Res.*, 7:10, Jan., 1965.

3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, *J.A.M.A.*, 178; 406, Oct., 1961.





BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.



## Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

### Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week — maximum reduction in seven to ten days.

## Less troublesome side effects may be seen; frequent improvement in “sense of well-being”

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily—that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.



# Prescribing information for **EUTRON**

**INDICATIONS:** Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

**CONTRAINDICATIONS:** Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

**WARNINGS:** Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of  $\frac{1}{4}$  to  $\frac{1}{5}$  the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has

been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

**PRECAUTIONS:** When determining the anti-hypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

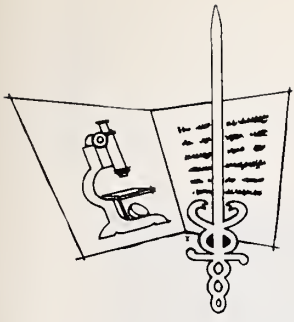
Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopenia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

**SIDE EFFECTS:** The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.



512214





### THE AMERICAN CANCER SOCIETY AND WHAT IT CAN OFFER TO A COMMUNITY

A. B. Conger, M.D.,\* *Columbus*

**T**HE AMERICAN CANCER SOCIETY offers each community the *best* opportunity of saving the lives of its citizens from cancer. It does this in three ways: First, it urges each citizen to have a cancer detection checkup each year designed to find cancer in a curable stage. Secondly, it educates the public to the danger signals of cancer so a person who develops cancer between examinations will know to go back to the doctor earlier; and Third, it supports research into the ultimate cause and cure of cancer so that this scourge can eventually be wiped off the face of the earth. In addition, the Society gives needy persons with cancer up to \$15.00 a month in pain relieving drugs. Local units have a loan closet that will help with bandages, beds, linens, transportation to and from free clinics, etc. But these additions have to be secondary to the basic aims of the Society—**TO SAVE LIVES NOW—AND TO LEAD THE RESEARCH ATTACK ON CANCER.**

#### To Pay the Cost

The cancer problem is so great that the Society can't even begin to pay the cost of treating cancer patients. This year, about 870,000 Americans will be under medical care for cancer at a total cost of one billion, 250 million dollars. Some 570,000 *new* cases of cancer will be diagnosed in the United States this year (9,500 in Georgia) and some 295,000 Americans will die of cancer (5,000 in Georgia).

One-fourth of all the money collected by the American Cancer Society must be used for research by "law" of the Society. The goal: To find what causes cancer. To find new ways to cure it. To find ways to prevent it. To alleviate pain and suffering.

The American Cancer Society is a great volunteer organization—worthwhile, unselfish and dedicated to its primary goal of *saving lives from cancer*. It can do

much for a community. It deserves our whole-hearted support. Eventually cancer will strike 49 million Americans who are now living; one in four persons; approximately two of three American families. In 1964, the Society raised a total of 45 million dollars. This amount would be only a drop in the bucket if used to treat cancer. But it is a flood of lifegiving when used to educate the public and doctors, and to do research.

#### Can Be Cured

Early cancer can usually be cured. This is attested to by the 1,400,000 Americans living today who have gone five years without a recurrence. The ranks of these will be swelled by 190,000 more Americans who will be saved from cancer this year. But it is estimated that there will be 95,000 cancer patients who will die needlessly in 1966 because of lack of knowledge about cancer or because of fear of having treatment. It is these 95,000 that we want to save this year or next year or the next—with methods now available. It is the entire 295,000 that die each year that we hope to eventually save through research.

#### Spreading the Message

The American Cancer Society uses all the means at its disposal to educate the public and physicians about cancer. Through meetings of every sort, through mass media, leaflets, films, etc., the Society spreads the message. The most effective educational technique is the two-way exchange, in which people have the opportunity to voice their own ideas, their own fears, and their questions about cancer and to hear the facts from the American Cancer Society. As regards physicians, the Society sends out much information of an educational nature and sponsors lectures and talks at various medical meetings.

711 Center Street

\* Dr. Conger is Chairman of the Board, Georgia Division of the American Cancer Society.

Approved by the Professional Education Committee, Georgia Division, ACS.



## *The Pain Is Gone*

Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

### **'Empirin'® Compound with Codeine Phosphate gr. 1/2 No. 3**

Each tablet contains: Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

Keeps the Promise of Pain Relief



BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.





## INTENSIVE CORONARY CARE UNITS

G. Y. Erwin, M.D., *Athens*

SEVERAL STUDIES during the last few years have shown the feasibility of intensive coronary care units. In these units all patients with acute coronary disease are monitored continuously in specially designed units. The patients are continuously under the visual observation of nursing personnel. The EKG is continuously shown on the oscilloscope. Changes in heart rate or rhythm set off an alarm to alert personnel to possible serious changes in the patient's condition. All necessary resuscitation equipment including respirators, defibrillators and pacemakers are at hand. The nurses are trained in interpretation of the cardiac arrhythmias, as well as emergency resuscitation techniques, external pacemaking and defibrillating.

### Reduction in Mortality

Results so far have shown a reduction in mortality of 20%-30% among patients treated in the units as compared with patients treated on general medical floors. The best results are obtained in the so-called good risk patients who suddenly develop ventricular tachycardia or fibrillation. Poor risk patients who are in prolonged shock and failure have not had a favorable reduction of mortality.

It is estimated that there are 500,000 deaths from coronary disease every year in the United States. A 20% reduction in mortality would save 100,000 lives annually. It has been suggested that all hospitals who

admit as many as 100 coronary cases a year could efficiently set up a coronary care unit of three or four beds. In smaller hospitals the unit could be part of an intensive care area. It is essential to have interested, specially trained nursing personnel. At the present time such training may be obtained by making special arrangements with existing coronary care units. A continuous inservice educational program is necessary. The unit should be under the supervision of an interested qualified physician.

### Plans for Organizing

Details on how to set up such a unit are outlined in *Modern Concepts of Cardiovascular Disease*, May and June, 1965. This is available on request from the Georgia Heart Association. "Coronary Care Units," Public Health Service Publication No. 1250, is available from the Public Health Service. "Intensive Coronary Care—A Manual for Nurses" by Dr. Lawrence Meltzer, is an excellent training guide for nurses, house officers and physicians. This manual may be obtained from CCU Fund, The Presbyterian Hospital, Philadelphia, Pennsylvania.

The cost for special equipment will run around \$2,000-\$3,000 per bed. This is a small investment if even one patient per year is saved by such special care.

1010 Prince Avenue

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

## THE DOCTOR DRAFT

The following information is furnished relative to the pending draft call for 1,529 physicians who will be ordered to active duty during the period January through April, 1966.

(1) Physicians receiving an order to report for physical examination does not necessarily mean that they will be called for induction.

(2) Procedure of the call will be those physicians who have attained age 26 in the order of their dates of birth with the youngest being selected first.

(3) Marriage or fatherhood are not grounds for deferment.

(4) Physicians are not vulnerable after reaching their 35th birthday.

(5) If a disproportionate number of residents are called from one hospital or one department or service

in a hospital, appeal should be made by calling the matter to the attention of the state medical advisory committee to Selective Service. Each state has such a committee.

(6) Residents participating in the Armed Forces Berry Plan will not be subject to this call.

(7) An appeal of classification must be made to the draft board within ten days after the date the local board mails the classification notice.

(8) The Soldiers and Sailors Relief Act of 1940, as amended, is applicable for the purpose of suspending enforcement of certain civilian liabilities of persons assigned to the Armed Forces. The provisions of this Act may be obtained from legal agencies of the Federal government or civilian attorneys.



## EDUCATION OF LAYMEN: POLICEMEN

Everett C. Kuglar, *Augusta*

THE IMPORTANT role of the police in handling psychiatric emergencies was stressed at a recent conference on psychiatric emergencies held at the APA Central Office in Washington. It was brought out at the conference that in a study of 800 calls to the police in Syracuse, New York, more than half of the calls involved interpersonal problems rather than criminal matters and that a number of the calls represented true psychiatric emergencies.

### Stories Carried

All too often newspapers throughout the country carry stories in which the police are called to subdue individuals who have destroyed articles within their homes, or have barricaded themselves, or have become upset and violent following drinking binges. The officers come abruptly upon the scene threatening and challenging the upset individual. There then frequently occurs a tragedy of some type. The officer involved may be injured or killed, the upset person may commit suicide, or may by necessity be seriously injured or killed by the police. It is only after the tragedy that it is learned that the individual may have been one of those who often becomes temporarily violent when drinking, or that he was actually begging for help prior to the arrival of the police.

The above incidents are cited to indicate the

need for education of the police in handling psychiatric emergencies. In the APA conference it was brought out by the discussants that especially for the poor and ignorant, the police are a stable source of support, and that many policemen have developed good techniques for handling interpersonal problems where there have been training programs sponsored by mental health associations and psychiatric facilities.

### Already in Existence

Some programs of this type are already in existence in Georgia. The Medical College of Georgia has recently held seminars for policemen, firemen, and other groups concerned with handling psychiatric emergencies and in dealing with upset individuals. More seminars of this type are planned for the future. It is also possible that other such conferences have been held from time to time at various facilities within the state. It is hoped, however, that both private medicine and the state's new mental health complex will combine efforts to establish educational programs for certain lay groups, such as the police, and that these programs will be a well-coordinated, regular feature in this state's mental health effort.

*Medical College of Georgia*

Prepared at the request of the Sub-committee on Mental Health of the Medical Association of Georgia.

## "WILLIAM OSLER MEDAL" STUDENT ESSAY CONTEST COMMEMORATES PHYSICIAN INTERESTED IN HUMANITIES

The William Osler Medal of the American Association for the History of Medicine is awarded for the best unpublished essay on a medico-historical subject written by a student in one of the medical schools in the United States or Canada. All students who are candidates for the degree of Doctor of Medicine, or who graduated in 1965, are eligible. This medal, first awarded in 1942, commemorates the great physician, Sir William Osler, who stimulated an interest in the humanities among students and physicians alike.

Essays should demonstrate either original research or

an unusual appreciation and understanding of a medico-historical problem. Maximum length is 10,000 words. The prize-winning essay will be submitted to the Editorial Committee of the Association, which may recommend it for publication in the *Bulletin of the History of Medicine*.

Essays must be submitted by March 23, 1966, to the Chairman of the Osler Medal Committee, William K. Beatty, Librarian and Professor of Medical Bibliography, Northwestern University Medical School, 303 East Chicago Avenue, Chicago, Illinois 60611.



# Butazolidin<sup>®</sup> alka

Each capsule contains:

Butazolidin, brand of phenylbutazone	100 mg.
dried aluminum, hydroxide gel	100 mg.
magnesium trisilicate	150 mg.
homatropine methylbromide	1.25 mg.

## in painful shoulder

## Geigy



### Therapeutic Effects

The acute phase of subdeltoid bursitis, tendinitis and associated periarticular inflammation usually responds promptly and dramatically to phenylbutazone. Pain and tenderness may be relieved within 24-48 hours and mobility of the affected arm quickly restored. Full recovery is frequently achieved within 7-10 days so that therapy is generally of short duration. Calcific deposits are not specifically affected by treatment, but their presence does not appear to retard symptomatic improvement.

Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

### Contraindications

Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

### Precautions

Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination,

including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

### Warning

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

### Adverse Reactions

The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use,

reversible thyroid hyperplasia may occur infrequently.

### Average Dosage

Initially, give 400 mg. daily (one capsule q.i.d), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. Butazolidin alka contains antacids and an antispasmodic to minimize gastric upset.

**Note:** The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

### Also available:

**Butazolidin<sup>®</sup>**  
brand of phenylbutazone  
Tablets of 100 mg.



Geigy Pharmaceuticals  
Division of Geigy Chemical Corporation  
Ardsley, New York

# THE ASSOCIATION



## DEATHS

THOMAS HENRY JOHNSTON of Brunswick, 75, died on June 20, 1965, after a long illness. Dr. Johnston was a Canadian by birth and received his medical training at the University of Manitoba Medical College. He interned at the Winnipeg General Hospital. He first came to Georgia in 1928 and was Public Health Director for Coffee County for a number of years; he was then in private practice at Douglas, Georgia, until 1945.

Dr. Johnston came to Brunswick in 1945 and was in private practice in that city until his health forced his retirement. He was a member of the Glynn County Medical Society and the American Medical Association. He is survived by his wife, Victoria I. Johnston, M.D., and his daughter, Joyce Ann Johnston of Brunswick.

## PERSONALS

Eighteen Georgia physicians were inducted into the American College of Surgeons at the recent annual five-day Clinical Congress held at Atlantic City, New Jersey.

New Georgia Fellows of the American College of Surgeons are:

### *Athens*

THOMAS A. MONTGOMERY

### *Atlanta*

RAY E. DELLINGER

JOSEPH H. DIMON, III

CHARLES R. HATCHER, JR.

WILLIAM E. HUGER, JR.

HAROLD J. LEFKOFF

MARTON MAJOROS

T. ELDER PEARCE

LUTHER C. ROLLINS

L. NEWTON TURK, III

THOMAS E. WHITESIDES, JR.

### *Carrollton*

TALMAGE M. MARTIN, JR.

### *East Point*

HUGH S. THOMPSON, JR.

### *Forest Park*

CLYDE C. HARRISON, JR.

### *Macon*

WALDO E. FLOYD, JR.

### *Savannah*

WILLIAM B. JONES, USAF

### *Smyrna*

EDWARD D. SNYDER

### *Dublin*

ROGELIO J. BARATA

### First District

RUFUS E. GRAHAM, 90-year-old Savannah physician, will retire this year after beginning his medical practice in 1904. Dr. Graham began practicing in Nunez and later moved to Stillwell, where he remained until called

into the service during World War I. He spent a year overseas and in 1919, Dr. Graham and his wife moved to Savannah. After 61 years of practice, Dr. Graham will work toward closing his office permanently in December.

### Fifth District

FRED ALLMAN, JR. of Atlanta, orthopedic surgeon and one of the attending physicians to the U.S. Olympic team in Japan, spoke October 21, 1965, at the family night supper at the Northside Methodist Church.

Twenty-one Atlanta physicians participated in the scientific program of the Southern Medical Association meeting held November 1-4, 1965, at Houston, Texas. They are: WILLIAM J. BROWN, SIDNEY OLANSKY, LESLIE C. NORINS, J. SPALDING SCHRODER, JAMES L. ACHORD, J. M. PERKINS, GRADY CLINKSCALES, DARIUS FLINCHUM, THOMAS E. WHITESIDES, ROBERT P. KELLY, JACK C. NORRIS, E. C. POUND, CHARLES P. YARN, WILLIAM HUGER, OSLER ABBOTT, WILLIAM D. LOGAN, H. HARLAN STONE, WILLIAM J. GARONI, JR., JOSEPH H. PATTERSON and CHARLES P. HATCHER, JR.

The White House has announced the appointment of WINSTON E. BURDINE, Atlanta, as a member of the Defense Executive Reserves which comes under the Office of Emergency Planning. The Executive Reserves will consist of 230 members and will meet at regular intervals in Washington, D. C. In the event of a national emergency they will be called on to devote more time to planning for the government. Dr. Burdine has long been active on the national level and at the present time is serving on the President's People to People Committee. He has been active in veterans affairs and various rehabilitation programs. On October 25, 1965, Dr. Burdine attended the first meeting of this group in Washington, D. C.

### Sixth District

The Medical Association of Georgia and the Georgia Farm Bureau Federation joined recently in sponsoring a Georgia Rural Health Conference held at Rock Eagle State Park, October 22-23, 1965. DR. GEORGE H. ALEXANDER, President of the Medical Association of Georgia and Farm Bureau President Lanier were on hand to provide the welcome to delegates from throughout the state. Others taking part in the seminar were DR. ADDISON M. DUVAL, Director of the Division of Mental Health for the Georgia Department of Public Health; A. R. Kenyon, past president of the Georgia Association for Mental Health; DR. RICHARD FELDER, of the Georgia Psychiatric Association; DR. W. D. STRIBLING, Chairman of the Mental Health Committee of the Medical Association of Georgia; Dr. W. Wyan Washburn, Chairman of the Council on Rural Health for the American Medical Association; Dr. Har-



vey Young, Professor of the Department of History of Emory University; Dr. Robert Caldwell, Professor of Dentistry at the University of Alabama Medical Center; Dr. Eleanor Petrie, Director of Nutrition Services Department of the Georgia Department of Public Health, and Miss Lucille Higginbotham, Extension Home Economist of the Health Education Department of the Cooperative Extension Service. Milton D. Krueger, the Executive Secretary of the Medical Association of Georgia served as panel moderator.

### Seventh District

The late father of a Rome physician who gained international recognition for his contributions to medical research is to be honored by the University of Western Ontario where he served as dean for 14 years. He is the late JAMES BERTRAM COLLIP, who died June 19, 1965, at the age of 72 after a brief illness. Dr.

Collip was the father of BARBARA COLLIP WYATT of Rome. A world-famed Canadian scientist, Dr. Collip, who was born in Belleville, Ontario, was a biochemist, purifier and co-developer (with Nobel Prize winners Sir Frederick Banting and Dr. J. J. R. McLeon, and Dr. Charles H. Best) of insulin for the treatment of diabetes. He also won world renown for his study of hormones, which regulate the body's metabolic functions, becoming one of the pioneers in the isolation of the wonder-working ACTH and cortisone.

The Medical Staff of Hamilton Memorial Hospital, Dalton, held its annual staff election for officers to serve during the fiscal year 1965-1966. Those elected, are MURRAY B. LUMPKIN, Director of the Judd Memorial Tumor Clinic; SHERWOOD JONES, Director of the Heart Clinic; JAMES A. REDFEARN, President; S. L. SELLERS, Vice-President, and R. L. RAITZ, Secretary.

## THE "GOOD SAMARITAN" LAW

Since the enactment of the first so-called "Good Samaritan" Law by the California Legislature in 1959, 31 other States have followed suit and adopted similar laws.

"Good Samaritan" is the name applied to those laws designed to protect physicians and others from inequitable mal-practice litigation growing out of treatment given at the scene of an emergency.

In 1962, an MAG sponsored "Good Samaritan" bill was enacted by the Georgia General Assembly—a fact not widely known judging from the number of inquiries received at MAG during recent months. In essence the Georgia statute provides that anyone who renders emergency care or treatment, in good faith and without charge, shall be immune from civil liability which may arise from the rendering of such treatment.

## NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

Allen, Marshall B., Jr. Active—Richmond	Medical College of Georgia Augusta, Georgia 30902	McLean, William R. Active—Cobb	296 Medical Square Marietta, Georgia 30062
Bernstein, Vidor DE-2—Richmond	Talmadge Memorial Hospital Augusta, Georgia 30902	Maddox, S. F. Active—Bibb	740 Hemlock Street Macon, Georgia 31201
Biggers, David C. Active—Cobb	Kennestone Hospital Marietta, Georgia 30061	Mayfield, George R. Active—Richmond	3406 Kamel Circle Augusta, Georgia 30904
Boddie, A. M. Active—Baldwin	240 N. Wayne Street Milledgeville, Georgia 31601	Milsap, James H., Jr. Active—DeKalb	403 E. Ponce de Leon Avenue Decatur, Georgia 30030
Brown, Walter Jr. Active—Richmond	Medical College of Georgia Augusta, Georgia 30902	Myers, Albert A. Active—DeKalb	51 S. Peachtree Street Norcross, Georgia 30071
Crenshaw, John T. Active—Camden-Charlton	905 Dilworth Street St. Marys, Georgia 31558	Oglesby, James W. Active—Dougherty	910 N. Jefferson St. Albany, Georgia 31701
Etheridge, John G. Active—Bibb	777 Hemlock Street Macon, Georgia 31201	Remy, Henry Active—DeKalb	1205 Columbia Drive Decatur, Georgia 30032
Eversole, Joseph W. Active—Bibb	Macon Hospital Macon, Georgia 31201	Rheney, Theodore B. Active—DeKalb	2701 N. Decatur Road Decatur, Georgia 30030
Flournoy, Edwin E., Jr. Active—Dougherty	614 N. Slappey Drive Albany, Georgia 31701	Somerlot, Warren A. Active—Cobb	Cherokee Medical Building Smyrna, Georgia 30080
Gauthier, P. D. Active—Bibb	Jeffersonville, Georgia 31044	Stoddard, Leland D. Active—Richmond	Medical College of Georgia Augusta, Georgia 30902
Gent, Jack Active—Gordon	200½ Park Avenue Calhoun, Georgia 30701	Syribey, John P. DE-2—DeKalb	Box 211, St. Joseph's Inf. Atlanta, Georgia 30303
Glover, Douglas D. Active—DeKalb	1422 Cherokee Street Marietta, Georgia 30062	Trice, John C. Active—C. W. Long	C & S Bank Building Athens, Georgia 30601
Gray, James R. Associate—DeKalb	69 Butler Street, S. E. Atlanta, Georgia 30303	Trippe, Judson R., Jr. Active—Cobb	1202 Church St. Marietta, Georgia 30060
Hudson, James B. Active—Richmond	Talmadge Memorial Hospital Augusta, Georgia 30902	Ward, M. Carolyn Active—Cobb	605 Campbell Hill Street Marietta, Georgia 30062
Jardina, Philip M. Active—DeKalb	711 Church Street Decatur, Georgia 30030	Weaver, Alexander H. S., Jr. Active—Richmond	Talmadge Memorial Hospital Augusta, Georgia 30902
Kelly, Sherrill B. Active—Bibb	235 Medical Court Forsyth, Georgia 31029	Zunker, Ellyn G. Active—Cobb	707 S. Atlanta Street Smyrna, Georgia 30080





# TUBERCULIN, TINE TEST

(Rosenthal) Lederle

**ideally suited for routine TB screening**

**accurate**—comparable to the older standard intradermal tests

**practical**—can be administered by nurses or other personnel

**convenient**—no refrigeration or other storage precautions

**economical**—stable for 2 years, self-contained disposable unit

Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. *Available* as the new individually-capped unit, boxes of 5, or in cartons of 25.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York 9635-5





## SUMMARY OF RECENT MAG COUNCIL AND EXECUTIVE COMMITTEE ACTIONS

(The full minutes from which these summaries have been abstracted are available to any MAG member upon request to the Journal.)

### Executive Committee of Council/August 29, 1965

*Treasurer's Report*—Approved as presented by Dr. Atwater.

*1966 Annual Session Scientific Program*—One specialty society had objected to holding their meeting on Sunday; after discussion it was agreed to grant permission for them to hold their meeting other than on Sunday with the remainder of the schedule remaining unchanged.

*Guest Speaker for General Scientific Program*—Theme will be "Geriatrics" with surgeon, internist and psychiatrist as speakers. A surgeon and psychiatrist having been obtained, an internist is needed, and Executive Committee voted to give authority to Annual Session Board Chairman to spend some of funds budgeted for Annual Session to obtain the speaker.

*Report of Ad Hoc Subcommittee on Medical Indigency*—Dr. A. E. Hauck, Chairman of the Ad Hoc Subcommittee of Medical Indigency, was recognized and began his presentation by stating that his committee was appointed by MAG Council for the purpose of investigating the problem of gradual and persistent effort on the part of certain federal and state agencies to provide increasing medical services not only to the medically indigent, but to the public at large. After several meetings of the committee and thorough investigation of all available material the members had agreed to recommend that (1) the medical profession underwrite the entire indigency programs in the state; and (2) a local professional board be appointed to rule on every indigency case in each county in order to receive care under each program. A social worker could present the information on each case to the board. After hearing the report, the following motion made by Dr. Atwater and seconded by Dr. McDaniel was that Dr. Hauck compose a summary report to the Executive Committee, which will be presented to Council. The Executive Committee further commended the Medical Indigency Subcommittee for their work.

*Fee Schedule Negotiating Committee*—Dr. Mauldin stated the recommendations of the House of Delegates were rather vague about the mechanics of the Fee Schedule Negotiating Committee and asked for Executive Committee's interpretation. To clarify the questions about chairmanship and responsibility, the Executive Committee on motion (Eldridge-McDaniel) voted to appoint the Chairman of the Insurance and Economics Board, Dr. Henry Jennings, as temporary chairman, and to allow the committee to elect the permanent chairman; and further that the committee make recommendations to the Executive Committee for subsequent report to the House of Delegates in 1966.

The committee is to meet on September 12, 1965, and Dr. Mauldin was asked to contact the following neurosurgeons in order to have representation of their specialty: Edgar F. Fincher, Atlanta; Robert Mabon, Atlanta; or William W. Moore, Atlanta, as there is no state neurosurgical organization.

*Associate Degree Nursing Programs in Georgia*—Dr. McDaniel reported that the MAG Nursing Liaison Committee had approved the proposed Associate Degree Nursing Program under the Board of Regents University System. This is a two year program to be conducted at certain junior colleges within the state in conjunction with a hospital of about 200 beds in the vicinity for clinical training. It would be a two year course and count as two years toward a baccalaureate degree. These graduates would then take the state board examinations and if they pass would become a registered nurse. On motion (Brown-Eldridge) it was voted to recommend approval of this program to Council.

*Special Activities Board Report Re Medical TV Programs*—Dr. Atwater, Chairman of the Special Activities Board, reported that the board met and discussed two subjects, namely: (1) programming medical TV films as professional postgraduate medical education for the physicians in Georgia; and (2) programming medical TV films for the general public. Dr. Atwater recommended that a discussion of this be brought to Council if the Executive Committee approved. On motion (Brown-Eldridge) it was voted to recommend to Council approval of the Special Activities Board recommendation that the postgraduate medical education TV programs be investigated; that the programming of medical television for the general public likewise be investi-

gated; and that the Special Activities Board be authorized to pursue whatever means is necessary to accomplish these projects.

*P.L. 89-97 (Medicare) Administration in Georgia*—Dr. Mauldin informed the Executive Committee that the programs which the Association is interested in are Title XVIII and Title XIX of P.L. 89-97. *Title XVIII* has Part A (King-Anderson) and Part B (Doctor Bill Insurance). These will probably be handled by an insurance carrier. *Title XIX* is the Kerr-Mills "plus" section. This has so changed the original Kerr-Mills that it will probably be called the "new Title XIX program" in the recently passed P.L. 89-97. This portion of the law will probably be handled by a state agency. Dr. Mauldin also read the suggested regulations from the U. S. Department of Health, Education and Welfare on Title XIX. This was received for information.

Dr. Alexander then stated that he had been in contact with Dr. Martin, Chairman of the State Board of Health, regarding a meeting of the Board of Health and the MAG Executive Committee, to discuss the matter of state agency administration of the Medicare law in Georgia.

After very lengthy discussion, on motion (Eldridge-Brown) it was voted to defer this matter until the September meeting of Council, at which time the physician members of the Board of Health wish to make a presentation on this matter, and that all parties concerned be notified MAG would desire and recommend that regardless of which agency administers the medicare program in Georgia, that MAG have an integral part in it.

On Title XVIII the following action was taken by the Executive Committee: On motion (Andrews-Atwater), it was voted that the Executive Committee go on record as favoring complete control of the medical administration of Title XVIII and other medical activities which the Association has been in control of such as the ODMC "Medicare" program and Kerr-Mills, and others along this line.

*Tri-County Medical Society Resolution*: This resolution which dealt with non-participation of physicians in the federal medicare program was read to the Executive Committee. On motion duly made and seconded, it was voted to send a copy of the TWX from the AMA dated August 10, 1965, to the Tri-County Medical Society, as well as the MAG of Delegates action on the matter.

*AMA Meeting on Medicare*: After discussion the Executive Committee voted to send Drs. Mauldin and Brown to represent MAG at the AMA Meeting on Medicare scheduled for October 16-17, 1965, in Chicago.

*Legislative Report*—Dr. Mauldin spoke on the "Heart Disease, Cancer, and Stroke Amendments of 1965" bill which is presently pending in the House Interstate and Foreign Commerce Committee, of which Congressman Mackay is a member. It has been learned in the past week that this bill may be reported out of committee within a few days.

*Headquarters Office Report*—Mr. Krueger reported on the following:

(a) *Nursing Liaison Committee Mailing*: On motion duly made and seconded, it was voted to pay the postage for this mailing out of the postage fund.

(b) *MAG Rural Health Conference*: The MAG Rural Health Committee is holding a Rural Health Conference, October 22-23, 1965, Rock Eagle Conference Ground, Eatonton, Georgia.

(c) *MAG Mental Health Conference*: The Mental Health Committee has proposed a meeting to which the leadership of certain county medical societies would be invited for the purpose of informing physicians in county medical societies as to the program and plans for Georgia's community mental health programs.

(d) *MSEA School Meeting*: The details of the recent Medical Society Executives Association meeting were given and received for information.

(e) *Specialty Society Charges for Secretarial Services*: Mr. Krueger was asked to bring costs on services to the September Executive Committee meeting.

(f) *Advertising in Roster*: The Editor of the *Journal* has requested permission to sell three ads for the roster. On motion (Jennings-Mauldin) it was voted to authorize the Editor of *JMAG* to solicit ads for the roster.

(g) *Research and Education Foundation for MAG*: Per-



## SUMMARY OF MINUTES / Continued

mission was granted to look into the matter with the MAG Attorney.

(h) *Administrative Consultant*: A review of office procedures, management practices, and overall review of Association Headquarters by another state executive secretary was suggested. It was voted to defer this until the November Executive Committee meeting.

### OLD BUSINESS—

(a) *Areawide Planning Meeting*: Dr. Mauldin reminded the Executive Committee that no plans for an areawide planning meeting had been made and Dr. Alexander was asked to write Dr. J. L. Mulherin, Augusta, who was appointed chairman of the committee to study the possibility of such a meeting, regarding the progress in this regard.

### NEW BUSINESS—

(b) *1966 Projects Meeting*: It was decided that no meeting will be held this year.

(c) *Crippled Children's Service Letter*: A letter from the Crippled Children's Service Director, Dr. Dixon A. Lackey, was read in which help was requested in clarifying the criteria for medical eligibility for services provided by the state through the aid of the medical and surgical specialists of the state. Dr. Alexander was asked to write a letter to Dr. Lackey stating that MAG is in favor of this and to let the Association know what is desired.

(d) *Advisory Committee of the Health Referral Service Program for Armed Forces Medical Rejectees*: On motion duly made and seconded it was voted to ask the President to appoint a representative from MAG to serve on this Advisory Committee.

(e) *Appointment of Three MAG members to Interim Committee to Study Problems, Laws and Procedures relating to Sex Crimes and Sex Offenders*: President Alexander informed the Executive Committee that he had appointed W. D. Stribling, M.D., Chairman of the MAG Mental Health Subcommittee; John Warkentin, M.D., President, Georgia Psychiatric Association; and Harrison L. Rogers, M.D., State MAG Legislative Chairman, to this committee and that they had agreed to serve.

(f) *State Commission on Aging Appointment*: Dr. John S. Atwater, Atlanta, was appointed.

(g) *State Department of Health Dietary Information Center*: In order to discuss the feasibility of establishing a Dietary Information Center in Georgia, Dr. Alexander was asked by the State Department of Health Nutrition Service to appoint a representative from MAG to attend a planning meeting on September 21, 1965 at the Department of Health. The Executive Committee voted to appoint Dr. M. D. Pittard, of Toccoa.

(h) *AMA National Symposium on Venereal Disease Control*: Mr. Krueger was asked to call Dr. Hackney of the CDC regarding his attendance at this symposium, and if so, to represent MAG and render a report to the Association.

(i) *Office Space for Georgia Association of Nursing Homes*: On motion (Mauldin-Atwater) it was voted to ask Mr. Krueger to work out feasible arrangements with the Georgia Association of Nursing Homes for the utilization of office space in the MAG Headquarters Building.

(j) *Professional Liability Inquiry*: Dr. Mauldin reported on a professional liability case and on motion (Jennings-Mauldin) it was voted to refer this matter to the Medical Defense Subcommittee for a report to the Executive Committee at the September meeting, if possible; and to inform the physician involved of this action.

(k) *Governor's Conference on Education*: The Executive Committee has been invited to attend the Governor's Conference on Education to be held in November. Received for information.

### Executive Committee of Council/September 25, 1965

*Treasurer's Report*—John Atwater, Association Treasurer, presented a summary-comparison report of MAG income and expenditures per the 1965 Association budget, which was approved. Dr. Atwater also presented a reimbursement item for Dr. Ben Gilbert, who attended the AMA School Child Health meeting in Chicago, as a representative of the Association's School Child Health Committee. Executive Committee then recommended to MAG Council for their consideration that approximately \$235.00 be appropriated from the contingent fund for this reimbursement. Dr. John Atwater also informed the Executive Committee that approximately \$1,500.00 would be needed to reimburse the ex-

penses of the MAG delegation to the AMA at the forthcoming special called session of the AMA House of Delegates, Chicago, October 2-3, 1965. It was recommended to MAG Council that this amount be appropriated from the Contingent Fund.

*Headquarters Office Report*—Mr. Krueger presented a request from Dr. Edgar Woody, Editor of the *Journal of the Medical Association of Georgia*, for approval of charging travel expenses of the Managing Editor of the *JMAG* for attendance at a State Journal Advertising Bureau meeting in Chicago. Executive Committee recommended that expenses involved in the Managing Editor's attendance at this forthcoming meeting be charged to the *Journal* account.

Mr. Krueger presented the previous Executive Committee discussion on the matter of charging specialty societies for secretarial services performed by MAG Headquarters Office staff. It was recommended that a letter be written to all specialty societies using such services about the possibility of a nominal labor charge due to an increase in the Headquarters Office activity plus the amount of time given to these secretarial services. This letter was to be written at the direction of MAG Finance Chairman Eldridge, and the information gained therein referred to the Finance Committee for report to the December Council meeting.

*Public Law 89-97*—President Alexander discussed certain implications of Public Law 89-97, known as "medicare."

Secretary Mauldin then presented a September 1, letter from the Travelers Insurance Company in which they expressed their concern about Public Law 89-97, and their desire to act as an administrative intermediary in the implementation of portions of this law. The Executive Committee recommended that Secretary Mauldin respond to this letter emphasizing that the Medical Association of Georgia wishes to maintain a relationship with this company should they become such an intermediary and that the Association would be pleased to advise and consult with this company on this matter.

Some discussion ensued on the duty of "utilization review" committees as outlined in P.L. 89-97. The Executive Committee recommended that MAG concern itself with "guidelines" for utilization review committees and requested that the Association President appoint an ad hoc committee to study this matter and make recommendations in guideline form for use by county medical societies.

The special called meeting of the AMA House of Delegates, to be held October 2 and 3, 1965, in Chicago, was discussed and received for information.

*Fee Schedule "Negotiating Committee" Report*—Dr. Henry Jennings, Chairman of the newly created Association "Negotiating Committee" reported on the organizational meeting of this committee held September 12, 1965, at MAG Headquarters. Dr. Jennings stated that the committee would meet again in mid-November of this year, and his report was received for information with commendation.

*Reconvened Meeting of Executive Committee of Council*—Chairman Alexander reconvened the Executive Committee of the Council of the Medical Association of Georgia on September 26, 1965, at the Stone Mountain Inn, Stone Mountain, Georgia, at 4:30 p.m.

Following adjournment of the Council meeting, the Executive Committee of Council appointed Dr. Charles Cowart of LaGrange, to choose committee members for the purpose of studying and planning in the field of community health services with Dr. Cowart to serve as Chairman of this committee. It was also recommended that he make a progress report to the Executive Committee of Council at either the October or November meeting.

### Council Meeting/September 25-26, 1965

*Report on the 1965 House of Delegates Actions Progress*—Dr. J. Frank Walker, Speaker of the MAG House of Delegates, reported on the MAG progress in carrying out the actions taken by the 1965 MAG House of Delegates. In summary, Dr. Walker stated that there were 38 separate actions of which some 17 have already been carried out by the Association. He further stated that 7 other actions were now in progress of being carried out, that 8 other actions would probably be carried out in the near future, and that some 6 actions of the House were still pending as little or no action had been taken on them. Dr. Walker stated that he would follow through on these last six actions in writing letters to the respective boards and committees to carry out the charge of the House, and that he would continue to



stimulate activity on any other actions yet to be complied with. This report was received for information.

*Legislative Affairs*—Drs. J. Frank Walker, Chairman of National Legislative affairs, and J. Harrison Rogers, Chairman of State Legislative affairs presented a detailed report on Association activity in these fields. After due discussion of the items emphasized in these reports, on motion duly made and seconded, the reports were approved by Council.

*Appointment of GaMPAC Board*—The communication from Dr. Milford Hatcher, Chairman of the GaMPAC Board of Directors, was presented to Council stating that the GaMPAC Constitution and By-Laws requires that the Council appoint nominees to the GaMPAC Board of Directors. On motion duly made and seconded, the Council voted to elect to the GaMPAC Board of Directors the following persons: Joseph A. Mulherin, Savannah, 1st District Chairman; Mrs. John Elliott, Savannah, Co-Chairman, 1st District; Mrs. Gray Fountain, Albany, Co-Chairman, 2nd District; Luther H. Wolff, Columbus, Chairman, 3rd District; Mrs. Charles Smith, Columbus, Co-Chairman, 3rd District; Earnest C. Atkins, Atlanta, Chairman, 4th District; Mrs. Harper Butterworth, Decatur, Co-Chairman, 4th District; Mrs. Milton Bryant, Atlanta, Co-Chairman, 5th District; T. A. Sappington, Thomaston, Chairman, 6th District; Mrs. Benjamin Bashinski, Jr., Macon, Co-Chairman, 6th District; Lee H. Battle, Jr., Rome, Chairman, 7th District; Mrs. Leo Smith, Waycross, Co-Chairman, 8th District; Hartwell Joiner, Gainesville, Chairman, 9th District; Mrs. L. G. Cacchioli, Hartwell, Co-Chairman, 9th District; R. H. Randolph, Athens, Chairman, 10th District; and Mrs. Park Jeans, Jr., Augusta, Co-Chairman, 10th District.

*AMA Delegates Report on June 1965 Session*—Dr. J. W. Chambers, Chairman of the MAG delegation to the AMA, reviewed the highlights of the June 1965 New York City session of the AMA House of Delegates. This report was received for information.

*Headquarters Office Report*—Mr. M. D. Krueger and Mr. James Moffett reported on the activities of the Headquarters Office; the forthcoming MAG 1966 Annual Session in Columbus; and other meetings convened by Association boards and committees. This report was accepted for information.

*Augusta Children's Medical Center*—Dr. Richard S. Owings and Dr. Gerald Holman from Augusta, presented data to MAG Council on the development of a children's medical center for the southeast to be located in Augusta, Georgia. Dr. Ellington of Augusta, presented the approval of the Augusta pediatricians and Dr. Harry O'Rear, President of the Medical College of Georgia, discussed the teaching and research potential. After further discussion, on motion (Jennings-Bishop), it was voted to defer action on this proposal until the December Council meeting, provided that the Richmond County Medical Society, and the Georgia Pediatric Society approved the proposal.

*AMA House of Delegates Called Meeting*—Dr. J. W. Chambers, of LaGrange, Chairman of the MAG delegation to AMA House of Delegates, informed the MAG Council that a special session of the AMA House of Delegates would be convened October 2-3, 1965, in Chicago, to discuss recently passed health care legislation and pending health care legislation. Dr. Chambers asked for a reaffirmation of the 1965 MAG House of Delegates policy on non-participation under the provisions of the "medicare" law, and on motion (Brown-Alexander), it was voted by Council that the MAG Delegates to AMA continue to abide by the MAG House action on "medicare" non-participation, and also oppose any action aimed at discrediting AMA leadership.

The Home Health Services portion of the new "medicare" law was discussed by Dr. Chambers and received for information.

*Report of MAG Attorney*—Mr. Francis Shackelford, MAG Attorney, discussed for information the implications of Social Security coverage for physicians as imposed by the new "medicare" law retroactive to January 1, 1965. He also discussed the property tax situation on the MAG Headquarters Office Building. This data was received for information.

*National Commission Community Health Services Forum*—Dr. Charles Cowart, a participant in the Atlanta Forum sponsored by the National Commission on Community Health Services, reported on his attendance at a three day meeting and by general agreement, it was recommended that the Executive Committee consider action on certain aspects of Dr. Cowart's report.

*New Revised Life of Georgia Plan*—Dr. Henry Jennings, Chairman of the MAG Insurance and Economics Committee, reported on the new Life of Georgia Insurance program for the membership of MAG and this was received for information.

*MAG Council Meeting Reconvened*—Dr. Martin expressed the need for (1) better liaison between MAG and the State Board of Health, and (2) a full discussion of Public Law 89-97 (medicare) as it related to a resolution by the State Board of Health to the Governor of Georgia requesting of him the designation of the State Health Department to implement this new law.

Dr. Smoot cited the Georgia Health Code Law of 1964, as it relates to the functions of the department. Dr. Martin stated that the State Board of Health is seeking the full support of MAG for the State Department of Health to administer appropriate portions of Public Law 89-97, and he gave reasons for such State Health Department participation in this administration.

Dr. Martin also expressed the following suggestions for Council consideration to improve the liaison between the MAG and the State Board of Health: (1) a Medical Advisory Committee to the Board appointed by MAG Council; (2) the MAG President to attend all State Board of Health meetings; (3) that MAG would invite the Chairman of the State Board of Health to attend MAG meetings; (4) that MAG furnish a half-page in the *Journal* for communication purposes, so that the State Board might better communicate with the MAG membership; and (5) that each State Board member would report twice a year to his respective district medical society. It was further emphasized that the State Board of Health is running the Department of Health in both policy and administration.

A period was then devoted to questions and answers to clarify the position of the State Board of Health on the new "medicare" law.

At this time, Dr. Jennings made a motion which was duly seconded by Dr. Eldridge, and this motion was discussed. During the discussion, Dr. Mauldin made a substitute motion, which was seconded by Dr. Alexander, and this motion was also discussed. At this point, Chairman Andrews recommended that the two persons presenting the motions get together to present a joint motion due to the similarity of the two motions previously presented. After a ten minute recess, Dr. Andrews suggested that both Dr. Jennings and Dr. Mauldin withdraw their previous motion and substitute motion and Dr. Jennings and Dr. Mauldin agreed to this. Dr. Jennings then presented the following motion, which was seconded by Dr. McDaniel and others:

"WHEREAS, the Medical Association of Georgia has a continuing interest in the provision of high quality health services for citizens of Georgia, and

"WHEREAS, it is obvious that shortly there will be the inception of expanded programs for the provision of health services in Georgia, and

"WHEREAS, the Medical Association of Georgia currently is in a position of advising and administering certain existing health service programs in a highly efficient and acceptable manner to all parties concerned, and is enjoying exceedingly favorable relationships with the Office of Dependents' Medical Care and the State Department of Family and Children Services.

"THEREFORE BE IT RESOLVED that the Medical Association of Georgia expresses interest in becoming an active participant in the formulation of state plans for these expanding health services, and

"BE IT FURTHER RESOLVED that the Medical Association of Georgia will make available its personnel, facilities, abilities and experience to any and all Agencies in administration of such programs, and

"BE IT FURTHER RESOLVED that the Kerr-Mills (OAA) portion of the Medicare program remain under the auspices of the Department of Family and Children Services, especially since it has done creditable work and has cooperated exceedingly well with the physicians throughout the state, and

"BE IT FURTHER RESOLVED that the standards and other implementation of P.L. 89-97 be administered through the Board of Health, especially since it is felt that it is more competent to care for the health needs of the people of Georgia."

After some discussion of this motion, the question was called and the motion was approved.



# NEWS NOTES

## QUOTA OF VOLUNTEER PHYSICIANS FOR PROJECT VIET-NAM TO BE INCREASED

The program director of Project Viet-Nam has reported after a recent fact-finding tour of South Viet-Nam that the Project's bi-monthly quota of volunteer physicians may soon be "increased significantly."

Dr. Edwin W. Brown, Jr., Associate Medical Director of Project HOPE and Program Director of Project Viet-Nam, said that the volunteer physicians now in South Viet-Nam "are doing an outstanding job and have expressed enthusiasm for their assignments."

### Extended Tours

According to Dr. Brown, some of the Project's 18 doctors now in the Southeast Asian country have said they plan to extend their tours of duty beyond the minimum period of 60 days.

"Because of the success of the program thus far," Dr. Brown reported, "both Vietnamese and American officials have requested that the quota of volunteer physicians be increased as rapidly as adequate facilities can be provided for them."

To meet the increasing demand, Dr. William B. Walsh, President of Project HOPE and The People-to-People Health Foundation, Inc., which administers Project Viet-Nam, said that the number of volunteers per two-month period probably will be boosted to 30 from the present quota of 20.

### Numerous Inquiries

Dr. Walsh pointed out that more than 100 physicians have applied for service under Project Viet-Nam and another 500 have inquired about the new project.

Project Viet-Nam was created last July at the urging of President Johnson. It is financed by the Agency for International Development and assisted in recruitment by the American Medical Association.

Under the program, doctors volunteer for a minimum of two months' service without pay, to administer to the medical needs of Vietnamese civilians injured in the war or suffering from the many natural ailments prevalent in that country. The greatest need is for orthopedic surgeons, general practitioners and specialists in internal medicine, Dr. Brown said.

Dr. Brown returned earlier this month from his first tour of Project Viet-Nam activities, which are in operation at Saigon, Da Nang, Bien Hoa, Can Tho, Rach Gia, My Tho, Nha Trang, Qui Nhon, Quang Tri, Bach Lieu, Quang Ngai and Phu Vinh.

### With Other Physicians

In his report, Dr. Brown said that "volunteer physicians are working in a variety of situations in the civilian hospitals, but in each instance the doctor is assigned to work with one or more American doctors or other free world physicians working in Viet-Nam on a long-term basis."

Continuity, according to Dr. Brown, is maintained by integrating the volunteers into the long-term medical teams.

The program director said that doctors interested in serving the Project may submit their queries or application to Project Viet-Nam headquarters at 2233 Wisconsin Ave., N.W., Washington, D. C.

## "BETSY FUND" CONTRIBUTIONS TO AID PHYSICIANS WHOSE HOMES AND OFFICES WERE DESTROYED BY HURRICANE IN LOUISIANA

The Louisiana State Medical Society is soliciting contributions to a "Betsy Fund" to aid physicians whose offices and homes were totally destroyed by Hurricane Betsy.

Dr. Charles B. Odom, president of the society, said, "we already know of three members of our Society residing in areas below New Orleans who were completely wiped-out by the hurricane. The purpose of the Louisiana State Medical Society Betsy Fund is to assist these physicians in getting reestablished as quickly as possible."

Flood losses, which caused the greatest damage to the offices and homes of these physicians, are not covered by insurance.

"Because there are so many appeals being made to assist Betsy victims," Dr. Odom stated, "we have decided to limit ours to the medical profession. We do not plan to solicit funds from the general public."

In discussing the need to aid these physicians, Dr. Odom pointed out that two of the doctors were young men who had only been in practice a short while.

"We feel that by helping these doctors, we are not only assisting our fellow physicians, but are also helping the storm-struck communities where these physicians practiced by restoring normal medical services," Dr. Odom added.

The Louisiana State Medical Society has already made cash grants to some of the physician hurricane victims and will distribute all of the proceeds of the Betsy Fund as quickly as possible.

All physicians are invited to contribute to the Louisiana State Medical Society Betsy Fund. Checks should be made to the Louisiana State Medical Society Betsy Fund, Room 1528, 1430 Tulane Ave., New Orleans, La. 70112.



## **PATHOLOGISTS SET POLICY FOR HOSPITAL BASED PRACTICE**

The official policy of the College of American Pathologists as set forth by the CAP Board of Governors on the practice of pathology in hospitals is as follows:

"Whereas, Pathology has been repeatedly defined as an integral part of the practice of medicine, and

"Whereas, The House of Delegates of the AMA, at a recent meeting in Chicago, adopted the following statement of Policy:

"'Hospital based' medical specialists are engaged in the practice of medicine. The fees for the services of such specialists should not be merged with hospital charges. The charges for the services of such specialists should be established, billed, and collected by the medical specialist in the same manner as are the fees of other physicians, and

"Whereas, Public Law 89-97, the Medicare program, provides for coverage of Pathology in such a manner, and

"Whereas, it is desirable for payment of all Pathology fees to be done in a uniform manner, now

"Therefore be it resolved, that it be the policy of the College of American Pathologists, that members of the College shall separate their professional fees from hospital charges and present their own bills to all patients expected to pay for services, and

"Be it further resolved, that hospitals shall not be designated as a billing agent for Pathologists, and

"Be it further resolved, that Pathologists set their fees according to the worth of their professional service, maintaining a zealous guard against abuses which would significantly increase the cost of medical care."

This position is in accordance with and in furtherance of the policy of the American Medical Association. CAP earnestly seeks to enlist physician support in assisting pathologists to make such changes in their arrangements with hospitals as are necessary to fully implement this policy.

## **NORMAN A. WELCH, M.D. ESSAY CONTEST ON MEDICAL ETHICS TO BE INITIATED IN 1966**

The American Medical Association, through its Judicial Council, will sponsor a Medical Ethics Essay Contest, open during this academic year to junior and senior students in accredited medical schools in the United States.

The contest, to be known as the Norman A. Welch, M.D. Essay Contest, is another step in the Judicial Council's Expanded Program on Medical Ethics, according to the joint announcement by F. J. L. Blasingame, M.D., AMA's Executive Vice President, and James H. Berge, M.D., Chairman of the Judicial Council.

### **Cash Prizes**

Cash prizes totaling \$1,000, made possible by a special appropriation by the AMA's Board of Trustees, will be awarded to the winning essays. First prize will be \$500, second prize \$300, and third prize \$200.

The contest is being named in honor of the late Norman A. Welch, M.D., a leading figure in American medicine for many years, who died September 3, 1964, while serving as the 118th President of the AMA.

Complete contest rules, as well as suggested essay topics, are available upon written request from the Department of Medical Ethics, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610. They also may be obtained at the offices of the medical school deans.

June 1, 1966, has been set as the deadline for entries in the contest, which the Judicial Council hopes will be continued on an annual basis. Awards in the 1965-66 contest will be announced at the AMA Clinical Convention, in November, 1966.

Judging of the contest will be by a Medical Ethics Essay Contest Committee, composed of prominent physicians, and by members of the Judicial Council.

## **"CIRCUIT COURSE" POSTGRADUATE EDUCATION CONTINUES THROUGH JANUARY AND FEBRUARY**

The 1965-1966 Georgia "Circuit Courses," sponsored by the Medical Education Board of the Medical Association of Georgia, and the Medical College of Georgia, Augusta, will continue through January and February as follows:

### **Waycross/Memorial Hospital**

January 4—Care of the Acutely Injured Patient

February 1—Optic, Neurological and Medical Disorders

### **Moultrie/Colquitt Hotel**

January 5—Care of the Acutely Injured Patient

February 2—Optic, Neurological and Medical Disorders

### **Dublin/VA Center Hospital**

January 6—Care of the Acutely Injured Patient

February 3—Optic, Neurological and Medical Disorders

### **Toccoa/Georgia Baptist Assembly Grounds**

January 11—Problems in Reproductivity and Infant Care

February 15—Care of the Acutely Injured Patient

### **Dalton/Hamilton Memorial Hospital**

January 12—Problems in Reproductivity and Infant Care

February 16—Care of the Acutely Injured Patient

### **Thomaston/Upson County Health Building**

January 13—Problems in Reproductivity and Infant Care

February 17—Care of the Acutely Injured Patient

For further information and registration data write: Department of Continuing Education, Medical College of Georgia, Augusta, Georgia 30902.

# **TWENTY-NINTH ANNUAL** **NEW ORLEANS GRADUATE MEDICAL ASSEMBLY** **TO BE HELD IN MARCH**

The twenty-ninth annual meeting of The New Orleans Graduate Medical Assembly will be held March 7, 8, 9 and 10, 1966, with headquarters at The Roosevelt Hotel.

## **Nineteen Guest Speakers**

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include fifty-four informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures, round-table luncheons and technical exhibits.

This program is acceptable for twenty-nine (29) accredited hours by the American Academy of General Practice.

The twenty-first annual clinical tour of the Assembly has been planned for this spring to allow doctors and their families to enjoy a delightful vacation in combination with a medical program. Following the meeting in New Orleans, the group will leave on Saturday, March 12, for an Around The World trip via air. The itinerary includes Hawaii, Tokyo, Nikko, Kyoto, Nara, Hong Kong, Bangkok, New Delhi, Agra, Jaipur, and Cairo. The return flight is scheduled for Tuesday, April 12. Complete itinerary and rates will be furnished upon request.

For information concerning the Assembly meeting and tour write Secretary, New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, Room 1528, New Orleans, Louisiana 70112.

---

## **THE 1966 MEMBERSHIP ROSTER OF THE MEDICAL ASSOCIATION OF GEORGIA** **WILL BE INCLUDED AS A SUPPLEMENT TO THE JANUARY 1966** **ISSUE OF THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA**

**T**he ideal way to distribute vital and timely health information to your patients is with the AMA's New Pamphlet Rack Program—8 selected pamphlets and a decorative, handy display rack.

You receive 200 pamphlets (25 each of 8 selected pamphlets) that are scientifically sound, easy-to-understand and written on a wide variety of subjects. They supplement your counsel to patients by covering pertinent and timely topics . . . heart disease, cancer, smoking, acne and other skin problems, first aid, medicines, weight reduction, and health examinations.

The handsome NEW metal pamphlet rack has a rich walnut grain finish that will enhance the decor of

your office or reception area. It is designed to help you display pamphlets neatly and attractively. Measuring 19 $\frac{3}{4}$ " x 5" x 9 $\frac{3}{4}$ ", the pamphlet rack can be placed on a table top or conveniently hung on the wall.

With your order you will also receive a complete catalog describing some 80 other AMA health education pamphlets from which refills may be chosen at any time.

**To order your 200 pamphlets and display rack, complete the coupon below. Mail it with your remittance of \$6.95 for each Program to the AMERICAN MEDICAL ASSOCIATION, 535 North Dearborn Street, Chicago, Illinois 60610.**

# **NEW** **PAMPHLET** **RACK** **PROGRAM** **200 PAMPHLETS**

and a handsome  
display rack **\$6.95**  
... now only



**I enclose \$** \_\_\_\_\_ to cover the cost of .... PAMPHLET RACK PROGRAM(S). I will receive one rack and 25 each of 8 selected pamphlets for every PAMPHLET RACK PROGRAM I order.

**Sorry, only  
paid orders  
can be  
accepted.**

NAME _____	
ADDRESS _____	
CITY _____	
STATE _____	ZIP _____ 8-16

**Mail to: AMERICAN MEDICAL ASSOCIATION/  
535 N. Dearborn St./Chicago, Ill. 60610**



# Index

## Volume 54 --1965

Month	Pages	Month	Pages	Month	Pages
January	1-30	May	141-170	September	291-320
February	31-64	June	171-240	October	321-348
March	65-110	July	241-266	November	349-390
April	111-140	August	267-290	December	391-434

### AUTHOR INDEX

Key to letter abbreviations appearing before page numbers:

- C—Cancer Page
- E—Editorial
- H—Heart Page
- L—Legal Page
- M—Mental Health Page

Authors	Page
Alexander, George H., M.D. ....	143
Allen, Richard J., M.D. ....	330
Anthony, James E., Jr., M.D. ....	50
Bennett, William H., M.D. ....	46
Blalock, John B., M.D. ....	92, 146
Bohorfoush, Joseph G., M.D. ....	324
Buchanan, Leslie C., M.D. ....	C-56
Broyles, Vernon, Th.D., D.D. ....	E-140
Burge, Dan, M.D. ....	150
Cabaniss, C. D., M.D. ....	H-261
Canby, John P., Major, M.C. ....	367
Chandler, Caroline A., M.D. ....	99
Cheney, Huddie L., M.D. ....	H-162
Clark, John R., M.D. ....	16
Clune, F. J., Jr., Ph.D. ....	252
Collins, Lewis R., M.D. ....	16
Conger, A. B., M.D. ....	C-417
Craig, James B., M.D. ....	324
Dees, Hoyt C., M.D. ....	301
Dorney, Edward R., M.D. ....	H-235
Edwards, Ernest G., M.D. ....	156
Eisenberg, M. Michael, M.D. ....	297
Engler, Harold S., M.D. ....	C-106

Authors	Page
Erwin, G. Y., M.D. ....	H-419
Evans, Edwin C., M.D. ....	E-374
Floyd, Waldo E., Jr., M.D. ....	48
Folger, Gordon M., M.D. ....	291
Franch, Robert H., M.D. ....	H-24, 38
Gallaher, B. Shannon, M.D. ....	116
Grady, Edgar D., M.D. ....	321
Greenblatt, Robert B., M.D. ....	267
Hamm, William G., M.D. ....	33
Hammond, E. Cuyler, Sc.D. ....	278
Hearin, David L., M.D. ....	C-161
Henry, Lamont, M.D. ....	E-338
Holman, Colin B., M.D. ....	391
Hudson, Thomas L., Major M.C. ....	304
Jones, Hurley D., M.D. ....	38
Knight, Arthur M., M.D. ....	243
Kuglar, Everett C., M.D. ....	M-420
Letton, A. H., M.D. ....	278, C-379
Mayer, W. Brem, Jr., M.D. ....	H-341
McCranie, E. James, M.D. ....	M-165
McCranie, Martha, M.D. ....	247
McDonald, J. Kenneth, M.D. ....	M-316
Merrill, Arthur J., M.D. ....	E-254, E-371
Mooney, A. John, M.D. ....	358
Moore, John L., Jr. ....	L-314, L-343, L-25, L-134, L-262, L-287
Morgan, Anne D., M.D. ....	153
Morrison, William N., M.D. ....	46
Morse, James O., M.D. ....	8
Mullins, D. Frank, Jr., M.D. ....	16
Nolan, Thomas R., M.D. ....	321
Oseasohn, R. O., M.D. ....	113
Pamplona, Paul A., M.D. ....	96
Patterson, H. Scott, M.D. ....	324
Patterson, Joseph H., M.D. ....	33
Paulson, Donald L., M.D. ....	351
Perdue, Garland D., Jr., M.D. ....	271
Peters, Hans J., M.D. ....	C-132

Authors	Page
Puebla, Ruben A., M.D. ....	267
Quilligan, E. J., M.D. ....	3, 113
Raines, J. A., M.D. ....	M-236
Randall, Henry, M.D. ....	H-107
Richmond, Marion B., M.D. ....	363
Robinson, Ira E., Ph.D. ....	252
Robinson, Paul H., M.D. ....	H-235
Schapiro, H., Ph.D. ....	297
Schatten, William E., M.D. ....	33
Sell, M. D., M.D. ....	M-387
Shackelford, Francis ....	L-383
Shamblin, James R., M.D. ....	304
Singletary, Elizabeth, M.D. ....	116
Spann, William B., Jr. ....	L-163
Staats, E. F., M.D. ....	121
Staton, Ted L., M.D. ....	46
Stelling, Frank H., M.D. ....	402
Stone, H. Harlan, M.D. ....	277
Sullivan, Daniel B., M.D. ....	399
Talledo, Eduardo, M.D. ....	395
Tillman, Samuel P., M.D. ....	H-381
Torpin, Richard, M.D. ....	274
Turner, Daniel R., M.D. ....	H-313
Wammock, Hoke, M.D. ....	C-259
Watt, Vance, M.D. ....	326
Wenger, Nanette Kass, M.D. ....	H-58, 153
White, Cecil A., Jr., M.D. ....	E-103
White, H. Chan, Jr., M.D. ....	12
White, Perry M., M.D. ....	C-22
Whitney, Douglass G., M.D. ....	H-285
Wiggins, Roy, M.D. ....	E-126
Wilber, Joseph A., M.D. ....	H-133
Wilson, John P., M.D. ....	C-233
Wilson, Joseph, M.D. ....	E-231
Wood, Donald E., M.D. ....	E-54
Woodward, E. R., M.D. ....	297
Yelton, Chestley L., M.D. ....	41
Zuspan, Frederick P., M.D. ....	395

### SUBJECT INDEX

Key to letter abbreviations appearing before page numbers:

- C—Cancer Page
- E—Editorial Page
- H—Heart Page
- L—Legal Page
- M—Mental Health Page

— A —

#### ABSTRACTS

Abstracts by Georgia Authors  
..... 108, 136, 166, 263, 317

#### ACHALASIA

Rcentgenologic Observations  
Concerning Pulmonary Complications  
of Achalasia (Holman) ..... 391

#### ADAMANTINOMA

Adamantinoma of the Tibia (Edwards) 156

#### ADOPTION

Normal Problems in Adapting to  
Adoption (McCranie) ..... 247

#### ALCOHOLISM

Alcoholism—A Community Problem,  
A Medical Responsibility (Mooney) 358

#### AMERICAN CANCER SOCIETY

The American Cancer Society and  
the Physician (Wilson) ..... C-233  
The American Cancer Society and  
What It Can Offer to a  
Community (Conger) ..... C-417

#### AMERICAN COLLEGE OF SURGEONS

Regional Program of the American  
College of Surgeons (Wammock) C-259

#### AMERICAN MEDICAL ASSOCIATION

AMA Annual Meeting Highlights .. E-282  
AMA Clinical Convention Highlights E-19  
AMA Delegates Special Session .... E-103  
AMA House of De'legates Calls  
Special Meeting at Chicago .... E-373

The New 1965 AMA Legislative Proposal on Health Care of the Aged .....	E-52
--	------

## AMNIOCENTESIS

Clinical Uses of Amniocentesis: A Review (Talledo and Zuspan) ....	395
---	-----

## AMPAC

What Did the PAC Movement Contribute in 1964 Elections? Plenty, Say Candidates (Wood) ..	E-54
--	------

## ANEMIA

Iron Loading Anemia (White) .....	12
-----------------------------------	----

## ANESTHESIOLOGY

A Study of the Effect of Phenergan and Vistaril in Combination with Demerol on Labor and Delivery (Dees) .....	301
The Airway in Head and Neck Surgery (Sullivan) .....	399

## ANTICOAGULANTS

Present Status of Long Term Anticoagulant Therapy in Coronary Artery Disease (Cheney) .....	H-162
---	-------

## ANTIMETABOLITES

The Use of Antimetabolites in "Connective Tissue" and "Autoimmune Diseases" (Merrill) ..	E-254
--	-------

## AORTO-ILIAC OCCLUSIVE DISEASE

Aorto-Iliac Occlusive Disease (Whitney) .....	H-285
--	-------

## APPENDICITIS

Recurrent Appendicitis After "Appendectomy" (Shamblin and Hudson) .....	304
---	-----

## AREA-WIDE HOSPITAL PLANNING

Area-Wide Hospital Planning— What Is It? .....	E-255
---	-------

## ARTERIOSCLEROTIC ANEURYSMS

Experience in Management of Arteriosclerotic Aneurysms (Perdue) .....	271
---	-----

## AUTOIMMUNE DISEASES

The Use of Antimetabolites in "Connective Tissue" and "Autoimmune Diseases" (Merrill) ..	E-254
--	-------

## — B —

## BACTERIAL ENDOCARDITIS

Prevention of Bacterial Endocarditis (Tillman) .....	H-381
---	-------

## BIRTH CONTROL

"Birth Control Decision" (Moore) ..	L-343
-------------------------------------	-------

## BRONCHITIS

The Etiological Role of Chronic Bronchitis in Obstructive Pulmonary Emphysema (Singletary and Gallagher) .....	116
---	-----

## BROWN, WALTER E.

Savannahian, Walter E. Brown, Chosen New MAG President-Elect ..	E-230
--	-------

## BURNS

Pseudomonas Toxemia of Burns, Its Origin, Significance, and Control (Stone) .....	277
---	-----

## — C —

## CALENDAR OF MEETINGS

7, 57, 81, 115, 152, 231, 251, 289, 310, 342, 409	
---	--

## CANCER

Adjunct Prophylactic Procedures with Radical Mastectomy to Decrease Recurrent Breast Cancer (Grady and Nolan) .....	321
Better to Live in South Africa or South Georgia? (Buchanan) ....	C-56
Cancer Registries (Peters) .....	C-132
Chondrosarcoma of Bone (White) ..	C-22
Do-It-Yourself Pap Smear Kit (Letton) .....	C-379

Experience with Carcinoma of the Colon in a Community Hospital (Watt) .....	326
Presurgical Irradiation for Bronchogenic Carcinoma (Paulson) ..	351
Regional Program of the American College of Surgeons (Wamrock) ..	C-259
Skin Cancer (Hearin) .....	C-161
Spontaneous Return of Function of Facial Muscles Following Radical Excision of Parotid Carcinoma (Schatten, Hamm and Patterson) ..	33
The American Cancer Society and the Physician (Wilson) .....	C-233
The American Cancer Society and What It Can Offer to a Community (Conger) .....	C-417
The Current Status of Regional Perfusion in the Chemotherapy of Cancer (Engler) .....	C-106

## CANCER REGISTRIES

Cancer Registries (Peters) .....	C-132
----------------------------------	-------

## CARDIAC PACEMAKERS

Artificial Cardiac Pacemakers (Robinson and Dorney) .....	H-235
--	-------

## CARDIOVASCULAR SYSTEM

Aorto-Iliac Occlusive Disease (Whitney) .....	H-285
Artificial Cardiac Pacemakers (Robinson and Dorney) .....	H-235
Cardiovascular Anomalies of Marfan's Syndrome (Randall) .....	H-107
Catecholamine Metabolism (Wilber) ..	H-133
Catheterization in Congenital Heart Disease (Franch) .....	H-24
Changing Concepts of Cardiovascular Disease in Children (Folger) .....	291
Digitalis Intoxication (Cabaniss) ..	H-261
Experience in Management of Arteriosclerotic Aneurysms (Perdue) .....	271
Intensive Coronary Care Units (Erwin) .....	H-419
Interstitial Pulmonary Edema ....	E-159
Orthostatic Hypotension .....	E-18
Present Status of Long Term Anticoagulant Therapy in Coronary Artery Disease (Cheney) .....	H-162
Prevention of Bacterial Endocarditis (Tillman) .....	H-381
The Differential Diagnosis of Left Ventricular-Right Atrial Shunts (Jones and Franch) .....	38
The Electrocardiogram of the Normal Newborn Infant (Wenger) .....	H-58
The Fetal Heart Rate (Quilligan) ..	3
Vertebral-Basilar Insufficiency Caused by Occlusive Diseases of the Subclavian Artery—The "Subclavian Steal Syndrome" (Mayer) .....	H-341
Viral Pericarditis (Turner) .....	H-313

## CATATONIA

Catatonia as a Cause of Fever of Undetermined Origin (Bohorfoush, Craig, and Patterson) .....	324
---	-----

## CATECHOLAMINES

Catecholamine Metabolism (Wilber) ..	H-133
--------------------------------------	-------

## CHEMOTHERAPY

The Current Status of Regional Perfusion in the Chemotherapy of Cancer (Engler) .....	C-106
---	-------

## CHRISTMAS MESSAGE

A Physician's Christmas Story (Broyles) .....	E-410
--	-------

## CONGENITAL DEFECTS

Chondro-Osteo-Dystrophy, Morquio- Brailsford Syndrome in a 49 Year Old Negro Male (Knight) .....	243
Congenital Anomalies of the Upper Extremity (Stelling) .....	402

## CONNECTIVE TISSUE DISEASES

The Use of Antimetabolites in "Connective Tissue" and "Autoimmune Diseases" (Merrill) ..	E-254
--	-------

## COUNTY SOCIETY OFFICERS

.....	86
-------	----

## — D —

## DEATHS

Adams, Guy H. ....	237
Boyd, Montague Lafayette, Sr. ....	62

Bunce, Allen H. ....	345
Burdine, James M. ....	28
Cain, Sylvester .....	169
Calhoun, E. Phinizy .....	237
Cornwall, Gibson Kelly .....	345
DeLoach, Arthur William .....	28
Head, Douglas, Sr. ....	109
Hodges, William A. ....	169
Johnson, Thomas Henry .....	422
Lancaster, Edgar M. ....	237
Lineback, Merrill I. ....	109
Logan, Joseph Colquitt .....	388
Mercer, Joseph B. ....	62
Mills, Clarence W., Jr. ....	28
Morrison, Howard J. ....	288
Mulherin, Philip A. ....	62
Peabody, Elizabeth .....	139
Phillips, William Parks .....	238
Powell, John Earnest, Sr. ....	28
Rhodes, Clarence Adair .....	388
Richardson, Jeff L. ....	238
Robbins, Allen Isaac .....	345
Sharpley, Helen .....	139
Simmons, J. O. ....	109
Singleton, Donald W. ....	28
Strickland, Lorin Van .....	318
Sydenstricker, Virgil P. ....	62
Townsend, Egbert M. ....	139

## DERMATOLOGY

Skin Cancer (Hearin) .....	C-161
----------------------------	-------

## DIABETES

Diabetes Detection (Evans) .....	E-374
----------------------------------	-------

## DIET

Nutritional Disease in Georgia (Clune and Robinson) .....	252
The Role of Starvation and Hypocaloric Diets in the Management of Obesity (Puebla and Greenblatt) ..	267

## DIGITALIS INTOXICATION

Digitalis Intoxication (Cabaniss) ..	H-261
--------------------------------------	-------

## DISTRICT SOCIETY OFFICERS

.....	85
-------	----

## DRUGS

A Study of the Effect of Phenergan and Vistaril in Combination with Demerol on Labor and Delivery (Dees) .....	301
Diagnosis and Treatment of Convulsive Disorders in Children (Allen) ....	330
Digitalis Intoxication (Cabaniss) ..	H-261
Mannitol and Acute Renal Failure (Wilson) .....	E-231
Newer Uses of Old Drugs in the Treatment of Urinary Tract Infections (Morse) .....	8
Present Status of Long Term Anticoagulant Therapy in Coronary Artery Disease (Cheney) .....	H-162
Sulfadiazine Prophylaxis Against Rheumatic Fever During Pregnancy: Its Safety as Regards the Infant (Morgan and Wenger) .....	153
The Use of Antimetabolites in "Connective Tissue" and "Autoimmune Diseases" (Merrill) ..	E-254

## — E —

## EDITORIALS

A Physician's Christmas Story (Broyles) .....	410
After Medicare, What? .....	256
AMA Annual Meeting Highlights ..	282
AMA Clinical Convention Highlights ..	19
AMA Delegates Special Session .....	103
AMA House of Delegates Calls Special Meeting at Chicago .....	373
An Urgent Request .....	18
Area-Wide Hospital Planning— What Is It? .....	255
A Welcome to Old Friends .....	127
Diabetes Detection (Evans) .....	374
Georgia Physicians to Receive Increased Benefits in Newly Revised Life Insurance Program .....	372
In Appreciation (Walker) .....	52
Interstitial Pulmonary Edema .....	159
It Takes a Smart Doctor to Stay Out of God's Way .....	309
MAG 1965 on Relative Value Study ..	257
Mannitol and Acute Renal Failure (Wilson) .....	231
Medical Education and the Practicing Physician .....	127
Medicare Rules Soon to Be Determined "Medicare"—The Second Half of a Long Ball Game .....	410
Orthostatic Hypotension .....	159
Radiologists and Hospital Charges ..	18



Recent Trends in Venereal Disease Rates .....	337
Regional Medical Complexes .....	308
Response to Journal Questionnaire ..	128
Richard Torpin and Placentation ..	282
Savannahian, Walter E. Brown, Chosen New MAG President-Elect .....	230
State Legislative Wrap-Up for 1965 ..	129
The Effects of Heat upon the Human Body (Henry) .....	338
The New Medical Law .....	307
The New 1965 AMA Legislative Proposal on Health Care of the Aged 52	
The Physician's Responsibility in Mental Health Programs .....	309
The Role of the Sympathetic Nervous System in Sodium Excretion (Merrill) .....	371
The T3 Test (Wiggins) .....	126
The Tune Is the Same .....	53
The Use of Antimetabolites in "Connective Tissue" and "Autoimmune Diseases" (Merrill) ..	254
Welcome Aboard .....	254
Welcome to Augusta (White) .....	103
What Did the PAC Movement Contribute in 1964 Elections?	
Plenty, Say Candidates (Wood) ...	54

## EMPHYSEMA

The Etiological Role of Chronic Bronchitis in Obstructive Pulmonary Emphysema (Singletary and Gallaher) .....	116
---	-----

## ENDOSCOPY

Complications of Endoscopy (Blalock) 92	
---	--

## EPIDEMIOLOGY

Recent Trends in Venereal Disease Rates .....	E-337
---	-------

## — F —

## FEVER OF UNDETERMINED ORIGIN

Catatonia as a Cause of Fever of Undetermined Origin (Bohorfoush, Craig, and Patterson) .....	324
---	-----

## — G —

## GROUP INSURANCE

Georgia Physicians to Receive Increased Benefits in Newly Revised Life Insurance Program E-372	
New, Improved Group Insurance Program Can Provide Additional Protection for You .....	349

## GYNECOLOGY

Vaginal Discharge in Children—A Practical Approach to Therapy (Canby) .....	367
---	-----

## — H —

## HEALTH CARE OF THE AGED

In Appreciation (Walker) .....	E-52
The New 1965 AMA Legislative Proposal on Health Care for the Aged .....	E-52
The Tune Is the Same .....	E-53

## HEAT AND ATHLETICS

The Effects of Heat Upon the Human Body (Henry) .....	E-338
---	-------

## HIATAL HERNIA

An Evaluation of Surgery for Hiatal Hernia and Peptic Esophagitis (Woodward, Schapiro, and Eisenberg) .....	297
---	-----

## HOSPITAL CHARGES

Radiologists and Hospital Charges ..	E-373
--------------------------------------	-------

## HOUSE OF DELEGATES CHICAGO MEETING

AMA House of Delegates Calls Special Meeting at Chicago .....	E-373
---	-------

## HYPERTHYROIDISM

Failure to Diagnose Hyperthyroidism (Burge) .....	150
---	-----

## — I —

## INFECTIONS

Bacteruria in Pregnancy (Quilligan and Oseasohn) .....	113
--	-----

Newer Uses of Old Drugs in the Treatment of Urinary Tract Infections (Morse) .....	8
Prevention of Bacterial Endocarditis (Tillman) .....	H-381
Pseudomonas Toxemia of Burns, Its Origin, Significance, and Control (Stone) .....	277
Recent Trends in Venereal Disease Rates .....	E-337
The Treatment of Felons (Anthony) ..	50
Viral Pericarditis (Turner) .....	H-313

## INTENSIVE CARE UNITS

Intensive Coronary Care Units (Erwin) .....	H-419
---	-------

## — J —

## JOURNAL ADVERTISERS

A Welcome to Old Friends .....	E-127
Welcome Aboard .....	E-254

## JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

An Urgent Request .....	E-18
Response to Journal Questionnaire E-128	

## — L —

## LUNG

Roentgenologic Observations Concerning Pulmonary Complications of Achalasia (Holman) .....	391
--	-----

## — M —

## MANNITOL

Mannitol and Acute Renal Failure (Wilson) .....	E-231
---	-------

## MARFAN'S SYNDROME

Cardiovascular Anomalies of Marfan's Syndrome (Randall) .....	H-107
---	-------

## MEDICAL ASSOCIATION OF GEORGIA

Annual Session, 1965	
Annual Session Highlights .....	173
Call for Scientific Exhibits .....	71
Candid Camera .....	228
Guest Speakers .....	77
Information .....	69
Official Call .....	69
Official Proceedings 111th Annual Session	
First Session, House of Delegates	
Monday, May 3, 1965 .....	177
Second Session House of Delegates	
Tuesday, May 4, 1965 .....	179
First General Business Session	
Sunday, May 2, 1965 .....	222
Second General Business Session	
Monday, May 3, 1965 .....	224
Third General Business Session	
Tuesday, May 4, 1965 .....	225
Program .....	77
Program Résumé .....	72
Section Chairmen .....	72
Voting Rules .....	76
Committees	
Adult Recipient Program .....	186
Annual Session .....	215
Blood Banks .....	212
Cancer .....	219
Constitution and Bylaws .....	197
Crippled Children .....	215
Disaster Medical Care .....	216
Finance .....	194
Headquarters Office .....	186
Hospital Activities .....	186, 212
Hospital Relations .....	213
Interprofessional Relations .....	200
Journal MAG .....	199
Legislation .....	217, 220
Maternal Infant Welfare .....	216
Medical Defense .....	189
Medical Education .....	190
Medical Indigency .....	215
Medicare .....	186
Medicine and Religion .....	207
Mental Health .....	11, 198
Occupational Health .....	190
Professional Conduct .....	214
Public Health .....	217
Public Service .....	207
Relative Value Study .....	197
School-Child Health .....	219
Special Activities .....	218
Weekly Health Column .....	208
Woman's Auxiliary Advisory .....	197
Woman's Auxiliary to MAG .....	200
Council Meetings	
Dec. 12-13, 1964 .....	60
March 27-28, 1965 .....	240
May 1, 1965 .....	290
May 4, 1965 .....	290

September 25-26, 1965 .....	426
Executive Committee of Council Meetings	
Nov. 22, 1964 .....	11
Dec. 12, 1964 .....	60
Feb. 14, 1965 .....	135
March 27, 1965 .....	239
May 1, 1965 .....	290
May 4, 1965 .....	290
July 11, 1965 .....	347
July 30, 1965 .....	347
August 29, 1965 .....	425
September 25, 1965 .....	426
Georgia Physicians to Receive Increased Benefits in Newly Revised Life Insurance Program .....	E-372
In Appreciation (Walker) .....	E-52
MAG 1965 on Relative Value Study E-257	
New Improved Group Insurance Program Can Provide Additional Protection for You .....	349
New Members	
26, 110, 130, 149, 227, 287, 303, 346, 423	
Officers and Committees .....	83
Personals .....	28, 63, 109, 140, 169, 238, 265, 288, 318, 345, 389, 422
President's Letter	
McDaniel .....	21, 55, 105, 131
Alexander .....	232, 258, 284, 340, 378
Jennings .....	311, 412
Roster—See Special Supplement	
Societies .....	28, 62, 109, 139, 169, 238, 265, 288, 318, 388

## MEDICAL EDUCATION

Medical Education and the Practicing Physician .....	E-127
The Role of the Medical School in Community Mental Health Programs (McCranie) .....	M-165

## MEDICAL LEGAL PROBLEMS

Advantages of Partnership (Moore) L-262	
Annual Legal Check Up (Spann) ..	L-163
"Birth Control Decision" (Moore) L-343	
Moral Turpitude (Moore) .....	L-134
Recording License (Moore) .....	L-287
Withdrawal of Consent (Moore) ..	L-25

## MEDICAL LEGISLATION

After Medicare, What? .....	E-256
In Appreciation (Walker) .....	E-52
Medicare Rules Soon to Be Determined .....	E-410
Medicare—The Second Half of a Long Ball Game .....	E-159
Regional Medical Complexes, the President's War on Heart Disease, Cancer, and Stroke .....	E-308
Social Security for Physicians (Moore) .....	L-314
State Legislative Wrap-up for 1965 E-128	
The New Medicare Law .....	E-307
The New 1965 AMA Legislative Proposal on Health Care of the Aged .....	E-52
The Tune Is the Same .....	E-53
What Did the PAC Movement Contribute in 1964 Elections?	
Plenty, Say Candidates (Wood) ..	E-54

## MEDICARE

Medicare Rules Soon to Be Determined .....	E-410
Medicare—The Second Half of a Long Ball Game .....	E-159
The New Medicare Law .....	E-307

## MENTAL HEALTH

A Community School for the Trainable Retarded Child (Newman) .....	M-27
Education of Laymen: Policemen (Kuglar) .....	M-420
Mental Health (McDonald) .....	M-316
Practical Application of a Psychiatric Concept (Raines) ..	M-236
Recent Conceptions of Depression (Richmond) .....	363
The Physician's Responsibility in Mental Health Programs .....	E-309
The Role of the Medical School in Community Mental Health Programs (McCranie) .....	M-165
Ultra, Short-Term Psychotherapy (Sell) .....	M-387
Well Baby Care: Untapped Portal of Entry to Family Care (Chandler) ..	99

## — N —

## NEUROLOGY

Diagnosis and Treatment of Convulsive Disorders in Children (Allen) .....	330
Vertebral-Basilar Insufficiency Caused by Occlusive Diseases of the Subclavian Artery—The "Subclavian Steal Syndrome" (Mayer) .....	H-341



## NUTRITIONAL DISEASE IN GEORGIA

- Nutritional Disease in Georgia (Clune and Robinson) ..... 252

## — O —

### OBESITY

- The Role of Starvation and Hypocaloric Diets in the Management of Obesity (Puebla and Greenblatt) ..... 267

### OBSTETRICS

- An Explanation of Placental Marginal Infarct Rings (Torpin) ..... 274  
A Study of the Effect of Phenergan and Vistaril in Combination with Demerol on Labor and Delivery (Dees) ..... 301  
Bacteruria in Pregnancy (Quilligan and Oseasohn) ..... 113  
Clinical Uses of Amniocentesis: A Review (Talledo and Zuspan) .... 395  
Richard Torpin and Placentation .. E-282  
Sulfadiazine Prophylaxis Against Rheumatic Fever During Pregnancy: Its Safety as Regards the Infant (Morgan and Wenger) ..... 153  
The Fetal Heart Rate (Quilligan) ... 3  
When Does Pregnancy Test Become Negative After Normal Delivery, Incomplete Abortion and Missed Abortion? (Mullins, Collins, and Clark) ..... 16

### ORTHOPEDICS

- Adamantinoma of the Tibia (Edwards) ..... 156  
Ankle Injuries (Yelton) ..... 41  
Chondro-Osteo-Dystrophy, Morquio-Brailsford Syndrome in a 49 Year Old Negro Male (Knight) ..... 243  
Chondrosarcoma of Bone (White) .. C-22  
Congenital Anomalies of the Upper Extremity (Stelling) ..... 402  
Hereditary Muscular Atrophy (Floyd) 48

### ORTHOSTATIC HYPOTENSION

- Orthostatic Hypotension ..... E-18

### OTOLARYNGOLOGY

- Serous Otitis Media (Staats) ..... 121

## — P —

### PAP SMEAR KIT

- Do-It-Yourself Pap Smear Kit (Letton) ..... C-379

### PEDIATRICS

- Changing Concepts of Cardiovascular Disease in Children (Folger) .... 291  
Diagnosis and Treatment of Convulsive Disorders in Children (Allen) ..... 330  
Sulfadiazine Prophylaxis Against Rheumatic Fever During Pregnancy: Its Safety as Regards the Infant (Morgan and Wenger) ..... 153  
Vaginal Discharge in Children, a Practical Approach to Therapy (Canby) ..... 367  
Well Baby Care: Untapped Portal of Entry to Family Care (Chandler) 99

### PELLEGRA

- Nutritional Disease in Georgia (Clune and Robinson) ..... 252

### PEPTIC ESOPHAGITIS

- An Evaluation of Surgery for Hiatal Hernia and Peptic Esophagitis (Woodward, Schapiro, and Eisenberg) ..... 297

### PHYSICIAN PARTNERSHIP

- Advantages of Partnership (Moore) L-262

### PLACENTA

- An Explanation of Placental Marginal Infarct Rings (Torpin) ..... 274  
Richard Torpin and Placentation .. E-282

### PLASTIC SURGERY

- Spontaneous Return of Function of Facial Muscles Following Radical Excision of Parotid Carcinoma (Schatten, Hamm, and Patterson) 33

### PNEUMOPERITONEUM

- Pneumoperitoneum as an Adjunct to Lobectomy (Blalock) ..... 146

## PREGNANCY TEST

- When Does Pregnancy Test Become Negative After Normal Delivery, Incomplete Abortion, and Missed Abortion? (Mullins, Collins, and Clark) ..... 16

## PSYCHIATRY

- Catatonia as a Cause of Fever of Undetermined Origin (Bohorfoush, Craig, and Patterson) ..... 324  
Normal Problems in Adapting to Adoption (McCranie) ..... 247  
Practical Application of a Psychiatric Concept (Raines) .. M-236  
Recent Conceptions of Depression (Richmond) ..... 363  
Ultra, Short-Term Psychotherapy (Sell) ..... M-387

## PULMONARY EDEMA

- Interstitial Pulmonary Edema .... E-159

## — R —

## RADIATION THERAPY

- Presurgical Irradiation for Bronchogenic Carcinoma (Paulson) 351

## RADIOLOGY

- Radiologists and Hospital Charges E-373  
Roentgenologic Observations Concerning Pulmonary Complications of Achalasia (Holman) ..... 391

## REGIONAL MEDICAL COMPLEXES

- Regional Medical Complexes, The President's War on Heart Disease, Cancer, and Stroke ..... E-308

## RELATIVE VALUE STUDY

- MAG 1965 on Relative Value Study E-257

## RELIGION AND MEDICINE

- Lord, Make Us Rich and Honest (Alexander) ..... 143

## RETARDED CHILDREN

- A Community School for the Trainable Retarded Child (Newman) ..... M-27

## — S —

## SEROUS OTITIS MEDIA

- Serous Otitis Media (Staats) ..... 121

## SMOKING AND HEALTH

- Smoking Habits and Health in Georgia and Other Southern States (Hammond and Letton) ..... 278

## SOCIAL SECURITY

- Social Security for Physicians (Moore) ..... L-314  
Social Security for Physicians: A Continuation (Shackelford) .... L-383

## SODIUM EXCRETION

- The Role of the Sympathetic Nervous System in Sodium Excretion (Merrill) ..... E-371

## SPECIALTY SOCIETY OFFICERS

- ..... 85

## SUBCLAVIAN STEAL SYNDROME

- Vertebral-Basilar Insufficiency Caused by Occlusive Diseases of the Subclavian Artery—The "Subclavian Steal Syndrome" (Mayer) ..... H-341

## SURGERY

- Adjunct Prophylactic Procedures with Radical Mastectomy to Decrease Recurrent Breast Cancer (Grady and Nolan) ..... 321  
An Evaluation of Surgery for Hiatal Hernia and Peptic Esophagitis (Woodward, Schapiro, and Eisenberg) ..... 297  
Aorto-Iliac Occlusive Disease (Whitney) ..... H-285  
Complications of Endoscopy (Blalock) 92  
Experience in Management of Arteriosclerotic Aneurysms (Perdue) 271

- Experience with Carcinoma of the Colon in a Community Hospital (Watt) ..... 326  
Pneumoperitoneum as an Adjunct to Lobectomy (Blalock) ..... 146  
Presurgical Irradiation for Bronchogenic Carcinoma (Paulson) 351  
Pseudomonas Toxemia of Burns, Its Origin, Significance, and Control (Stone) ..... 277  
Recurrent Appendicitis After "Appendectomy" (Shamblin and Hudson) ..... 304  
The Airway in Head and Neck Surgery (Sullivan) ..... 399  
The Differential Diagnosis of Left Ventricular-Right Atrial Shunts (Jones and Franch) ..... 38

## SYMPATHETIC NERVOUS SYSTEM

- The Role of the Sympathetic Nervous System in Sodium Excretion (Merrill) ..... E-371

## — T —

### T3 TEST

- The T3 Test (Wiggins) ..... E-126

### THERAPY

- Adjunct Prophylactic Procedures with Radical Mastectomy to Decrease Recurrent Breast Cancer (Grady and Nolan) ..... 321  
Catatonia as a Cause of Fever of Undetermined Origin (Bohorfoush, Craig, and Patterson) ..... 324  
Diagnosis and Treatment of Convulsive Disorders in Children (Allen) .... 330  
Prevention of Bacterial Endocarditis (Tillman) ..... H-381  
Vaginal Discharge in Children—A Practical Approach to Therapy (Canby) ..... 367

### THYROID

- Failure to Diagnose Hyperthyroidism (Burge) ..... 150  
The T3 Test (Wiggins) ..... E-126

### TORPIN, RICHARD

- Richard Torpin and Placentation .. E-282

### TUBERCULOSIS

- Tuberculosis Within the Family Unit (Pamplona) ..... 96

## — U —

### UROLOGY

- Bacteruria in Pregnancy (Quilligan and Oseasohn) ..... 113  
Mannitol and Acute Renal Failure (Wilson) ..... E-231  
Newer Uses of Old Drugs in the Treatment of Urinary Tract Infections (Morse) ..... 8  
Stenosis of the Urethral Meatus (Bennett, Morrison, and Staton) .. 46

## — V —

### VENEREAL DISEASE

- Recent Trends in Venereal Disease Rates ..... E-337

### VIRAL PERICARDITIS

- Viral Pericarditis (Turner) ..... H-313

## — W —

### WELCOME TO AUGUSTA

- Welcome to Augusta (White) .... E-103

### WELL BABY CARE

- Well Baby Care: Untapped Portal of Entry to Family Care (Chandler) 99

### WOMAN'S AUXILIARY, MEDICAL ASSOCIATION OF GEORGIA

- Fortieth Annual Meeting  
President's Invitation ..... 87  
Program ..... 87  
Rules ..... 89  
Welcome to Augusta ..... 87  
Organization ..... 90  
Roster—See Special Supplement

### WOOD, DR. HUGH

- "It Takes a Smart Doctor to Stay Out of God's Way" ..... E-309











THE LIBRARY  
UNIVERSITY OF CALIFORNIA  
San Francisco Medical Center

THIS BOOK IS DUE ON THE LAST DATE STAMPED BELOW

7 DAY LOAN

NOV 30 1966  
RETURNED

NOV 25 1966

7 DAY

JUL 28 1967

JUL 26 1967

7 DAY

OCT 20 1971

RETURNED

OCT 20 1971

7 DAY

JAN 30 1973

RETURNED

JAN 29 1973

10m-1,'66(G273s4)4315



St.



192746

